STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105810	A. Building B. Wing	04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Miracle Hill Nursing & Rehabilitation Center, Inc	1329 Abraham Street Tallahassee, FL 32304

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 28603 Based on record review, staff interview, and policy review, the facility failed to follow pharmacy documentation procedures for administration of medications for 2 of 4 sampled residents receiving thyroid medications. (Resident #2 and #3) The findings include: Resident #2 A review of Resident #2's January, February, and March 2025 physician orders and medication administration record (MAR) revealed that Resident #2 was ordered to receive Levothyroxine 125 mcg by mouth daily at 6:00 AM for hypothyroidism through 3/10/25. The MARs for January, February, and March 2025 revealed that the medication was not signed off as administered on 1/10/25, 1/19/25, 1/27/25, 2/2/25, 2/16/25, 3/3/25, 3/7/25, and 3/8/25. A physician order revealed that the Levothyroxine dose was increased to 150 mcg daily on 3/11/25. The March 2025 MAR revealed that the 150 mcg dose was blank and not signed of as administered on 3/30/25. Resident #2's record revealed that the resident was seen by a metabolic physician assistant (PA) on 12/18/24. The note documented by the PA indicated the lab results on 12/11/24 had a high thyroid stimulating hormone reading. The resident stated she had not been taking her medication lately and the dose of Levothyroxine was increased. A follow up visit with the same PA was documented on 3/18/25. The PA documented her labs on March 4, 2025 had a high thyroid stimulating hormone reading. The March note indicated it looks like the patient has not been taking her levothyroxine replacement at the nursing facility. The plan indicated the dose of Levothyroxine would be increased again and the patient's daughter would try to take over giving the thyroid medication. Resident #3 A review of Resident #3's medical record revealed current physician orders indicating he is ordered to receive Levothyroxine 75 mcg by mouth daily at 6:00 AM. The February 2025 MAR indicated no documentation of the Levothyroxine administration on 2/3/25, 2/8/25, 2/13/25, 2/21/25, and 2/27/25. The March 2025 MAR indicates no documentation of the Levothyroxine medication administration on 3/3/25, 3/7/25, 3/18/25, and 3/22/25. (continued on next page)

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Director of Nursing (DON) on 4/15/25 at 9:37 AM. The DON stated documentation of medication administration should occur at the time of administration. The DON was aware of Resident #2's labs and the daughter had reported she was coming in the evening and administering the levothyroxine. The facility had to educate the daughter against doing so as it could cause the resident to be overmedicated. Review of the facility policy Documentation of Medication Administration (revised November 2022; version 1. 2) revealed that a medication administration record is used to document all medications administered. Administration of medication is documented immediately after it is given.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28603 Based on observations, staff interview, document review, and policy review, the facility failed to maintain a fully functional resident call system in 4 of 8 sampled facility bedrooms. (Rooms 11, 36, 18, and 48) The findings include: An observation of bedroom [ROOM NUMBER] (A and B beds) was conducted on 4/14/25 at 1:24 PM. The bedroom call light system was tested for both A and B bed and found to be not functional. An observation of bedroom [ROOM NUMBER] (A and B beds) was conducted on 4/14/25 at 1:50 PM. The bedroom call light system was tested and found to be not functional. An observation of unoccupied resident bedroom [ROOM NUMBER] was conducted on 4/15/25 at 9:18 AM. Resident bedroom [ROOM NUMBER]'s call light system was not functional. An observation of unoccupied resident bedroom [ROOM NUMBER] was conducted on 4/15/25 at 9:22 AM. Both A and B bed were missing call lights cords rendering the call system for room [ROOM NUMBER] not functional. (Photographic evidence obtained.) An interview was conducted with the Administrator on 4/14/25 at 3:05 PM. When asked how the facility monitored the functionality of the resident call system, he stated a company comes in every 6 months to check the entire system. He stated they were in the facility about 2 weeks ago and identified they needed some replacement call light boxes. He acknowledged that the resident call system was old. The Administrator was asked if he had any evidence of the facility staff checking the call light system between the 6 months visits conducted by the company. The Administrator provided 2 service request documents from dated 3/4/25 indicating that the call system is obsolete and is working to quote a new system. Bad call stations were found in rooms [ROOM NUMBER]. Another invoice dated 3/28/25 indicated again they went over the nurse call system with customer. This invoice again stated that rooms [ROOM NUMBER] needed new call stations. The invoice stated, System is obsolete and cannot order new parts for repair. Customer is going to look for parts for repairs. A follow-up interview was conducted with the Administrator on 4/15/25 at 12:16 PM. He stated a company had to make parts for the resident call system and that was why it took so long to get parts for repairs. He was able to provide an audit from 3/11/25 for all call lights in facility, which indicated that the resident call system in room [ROOM NUMBER]B bed was not working and repaired on 3/12/25, the light for the 39B bed was not working and repaired 3/12/25, the lights for room [ROOM NUMBER] A and B were not working and repaired on 3/12/25, and 50 B bed not working and repaired on 3/12/25. He stated that was the only audit he could find. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy for Residents Call System (revised September 2022; version 1.0) states, residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized work station. The resident call system remains functional at all times. The resident call system is routinely maintained and tested by the maintenance department. Review of an additional undated facility policy for Maintaining Call Light System in Nursing Home indicated Miracle Hill Nursing and Rehabilitation Center is committed to maintaining a fully operational call light system that meets the needs of our residents. Regular monitoring, maintenance, and timely repairs are crucial to ensure compliance with federal and state regulations. The maintenance staff will routinely conduct an inspection of the call light system to ensure that all components are functioning properly. If the maintenance staff identified a problem that cannot be resolved during monthly monitoring, they will attempt to trouble shoot the issue using their training skills. If the issue remains unresolved, the maintenance staff will contact the outside contractor for immediate assistance.