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	08/27/2025

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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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(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 - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and facility policy review, the facility failed to implement the plan of care for 1 of 4 residents sampled for medication administration (Resident #3).The findings include:On 8/26/25 at 10:45 AM, an interview was conducted with Resident #3. He stated he had not received one medication, a Clonidine patch (a medicine used to treat high blood pressure but can also treat Attention Deficit Hyperactivity Disorder), for weeks. Resident #3 further stated nursing had told him the pharmacy delivered a pill instead of a patch. On 8/26/25, a review of Resident #3's medical record was conducted. The resident was admitted to the facility on [DATE] from hospital. Resident #3 had diagnoses that included bipolar disorder. The plan of care included administering medications as ordered related to behavioral problems. Physician's orders included Clonidine HCL tablet 0.2 mg apply transdermally every Wednesday for behavior/mood.The Medication Administration Record (MAR) revealed Resident#3 did not receive the Clonidine patch on 8/13/25 and 8/20/25. The MAR indicated see progress notes on these dates. Progress notes dated 8/13/25 stated Clonidine HCl Oral Tablet 0.2 mg, apply 0.2 mg transdermal one time a day every Wed for Behavior/Mood not available, reordered. Progress notes dated 8/20/25 stated Clonidine HCl Oral Tablet 0.2 MG Apply 0.2 mg transdermal one time a day every Wed for Behavior/Mood on order. Hospital discharge medications dated 8/3/25 stated to continue clonidine HCL 0.2 mg transdermal every Wednesday. On 8/26/25 at 11:03 AM, an interview was conducted with Staff A, Licensed Practical Nurse (LPN). She was aware that Resident #3 had a pill instead of a patch delivered by pharmacy. She stated she had notified the Director of Nursing (DON) today. On 8/26/25 at 3:53 PM, an interview was conducted with the DON. She stated she did not understand how the Pharmacy did not identify the fact that the medication was supposed to be a patch. She further stated that the receiving nurse should have looked at the order and called the Pharmacy instead of accepting the medication. On 8/27/25 at 11:12 AM, the DON provided pharmacy reorder forms faxed to the Pharmacy on 8/13/25. The reorder form requested Clonidine 0.2 mg patch for Resident #3. The DON reviewed the discharge order from the hospital stating Clonidine 0.2 mg patch and compared with the order entered upon admission on [DATE] stating Clonidine 0.2 mg tablet to be given transdermal. The DON stated the expectation was for nurses to communicate with unit manager and notify the Medical Director to clarify the order. On 8/27/25 at 11:37 AM, an interview was conducted via telephone with the Medical Director. He was made aware of the issue with Resident #3 not receiving the medication ordered because of the discrepancy on Resident#3's order placed into the electronic medical record and subsequent medication administration record. The Medical Director stated he would expect either the pharmacy or the nurses to contact him to clarify the order if needed. The facility policy named Pharmacy Services Overview (revised April 2019) states, Nursing staff communicate prescriber orders to the pharmacy and are responsible for contacting the pharmacy if a resident's medication is not available for administration. The facility policy named Administering Medications (revised April 2019) states, Medications are administered in a safe and timely manner, and as prescribed. Bullet 4 states medications are administered in accordance with prescriber orders, including any required time frame. The facility policy named Accepting delivery of medications (revised November 2022) states, Any errors in receiving medications are brought to the attention of the pharmacist and director of nursing services. Policy further stated the dispensing pharmacy, consultant pharmacist, and director of nursing services were notified of medication order errors. The facility policy named, Medication and Treatment orders (revised July 2016) states, Orders for medications and treatments will be consistent with principles of safe and effective order writing. Bullet 9 states orders of medications must include: a name and strength of the drug. B. number of doses, start and stop date, and/or specific duration on therapy; c. dosage and frequency of administration d. route of administration e. clinical condition or symptoms for which the medication is prescribed f. any interim follow-up requirements (pending culture and sensitivity reports, repeat labs, therapeutic medication monitoring, etc.)The facility policy named Medication orders (revised November 2014) states, The purpose of this procedure is to establish uniform guidelines in the receiving and recording of medication orders. Medication orders: when recording orders for medication, specify the type, route, dosage, frequency and strength of the medication ordered.