STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105882	A. Building B. Wing	09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winkler Court	3250 Winkler Avenue Extension Fort Myers, FL 33916

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37256 Based on record review and interview, the facility failed to ensure licensed nurses have the specific competencies and skill sets to provide nursing and related services to care for residents needs for 2 (Residents #1 and #2) of 3 residents reviewed for medication orders. The findings included: Facility policy Physician Orders 4.3.1 effective October 2021 indicated on page 3: The nurse will review each hard chart for new orders and compare to the electronic order listing report to ensure each written order has been entered into the electronic medical record. If a written physicians order is found on the chart and not on the order listing, transcribe the order and notify the resident/representative. Medication/Treatment variance may be completed if needed with physician notification. Facility Policy titled Event Reporting effective 2019, change date March 2022 indicated: An event report will be completed by the nurse assigned to the resident, for any occurrence outside the routine operational expectation of the facility. This includes but may not be limited to: Medication variance. Events/accidents will be investigated thoroughly, completely and timely. On 9/5/24 at 4:04 p.m., the Director of Nursing (DON) said the process for entering orders when a patient is transferred in from the hospital is: Hospital nurse to facility nurse report is given. Admissions provides nursing with the patients' paperwork prior to admission, which is reviewed, and orders are placed into the electronic chart (PCC). Once the patient arrives at the facility the doctor is contacted for clarification of any medications. Medications are not activated until they speak to the provider. As soon as activated it is sent automatically to the pharmacy. The paper chart never gets sent to pharmacy; the pharmacy only orders what is entered in PCC. Provider will come into building after they've already done verbal orders, on the phone, to review the orders and sign off on them. The orders are printed out on a Medication Review Report and put in a folder to be signed off by the provider. The DON said there were 3 checks on the medications: you will see a check mark on the medication reconciliation from the hospital which indicates the initial review by nurse that entered the meds into PCC, night shift fills out a form that they did a 24 hour chart check, and in the morning meeting all new resident charts are brought to the meeting and gone through one by one. This is documented on the admission checklist. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105882	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/06/2024
NAME OF PROVIDER OR SUPPLIER Winkler Court		STREET ADDRESS, CITY, STATE, ZIP CODE 3250 Winkler Avenue Extension Fort Myers, FL 33916	

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review revealed that on 8/13/24 Resident #1 returned to the facility after a hospitalization for problems with her feeding tube and aspiration pneumonia. The discharge orders from hospital included an order for Hydrocortisone sodium succinate 100 mg (milligram) injection, inject 20 mg into vein every morning. (corticosteroid medication used to replace the hormone cortisol which the body can no longer produce on its own) Record review of Resident #1's Medication Administration Record (MAR) for August 2024 did not reveal an order for daily hydrocortisone. Instead, it showed an order for Hydrocortisone inject 20 mg intramuscularly one time a day for Aspiration Pneumonia with an order date of 8/13/24 and discontinued on 8/14/24. This intramuscular injection was given one time on 8/14/24. No further hydrocortisone was given to Resident #1 following this injection during this stay. Chart review revealed no documentation in nursing progress notes, Advanced Registered Nurse Practitioner (ARNP) notes, or physician notes about discontinuing daily hydrocortisone for Resident #1. On 9/5/24 at 1:54 p.m., the ARNP said Resident #1 had a history of respiratory distress related to aspiration pneumonia. She said she ordered a one-time dose of intramuscular hydrocortisone related to respiratory distress. ARNP said she was not aware of the hospital order for daily steroids and was not aware Resident #1 did not get steroids beyond 8/14/24. ARNP said it was never brought to her attention about the daily order and said it was not something she discontinued. She said had she known about it, she would definitely have put her on a daily oral steroid dose. ARNP said her order for a one-time dose had nothing to do with the daily hydrocortisone order from the hospital, but with pneumonia. On 9/5/24 at 3:06 p.m., Staff A Registered Nurse (RN) Unit manager said she entered the hospital orders for Resident #1 into the computer. She said the facility does not do intravenous push (IVP) medications. She said she had discussed the hydrocortisone order with the ARNP and received a verbal order for a one-time dose to be given intramuscularly for pneumonia and Staff A discontinued the daily order. She said the only documentation of this would be the entry of the order into PCC. There were no progress notes for either nursing or the ARNP of the discussion of a one-time dose and discontinuance of daily hydrocortisone order. (continued on next page)

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/5/24 at 4:04 p.m., the Director of Nursing (DON) said the process for entering orders when a patient is transferred in from the hospital is: Hospital nurse to facility nurse report is given. Admissions provides nursing with the patients' paperwork prior to admission, which is reviewed, and orders are placed into the electronic chart (PCC). Once the patient arrives at the facility the doctor is contacted for clarification of any medications. Medications are not activated until they speak to the provider. As soon as activated it is sent automatically to the pharmacy. The paper chart never gets sent to pharmacy; the pharmacy only orders what is entered in PCC. Provider will come into building after they've already done verbal orders, on the phone, to review the orders and sign off on them. The orders are printed out on a Medication Review Report and put in a folder to be signed off by the provider. The DON said there were 3 checks on the medications: you will see a check mark on the medication reconciliation from the hospital which indicates the initial review by nurse that entered the meds into PCC, night shift fills out a form that they did a 24 hour chart check, and in the morning meeting all new resident charts are brought to the meeting and gone through one by one. This is documented on the admission checklist. The DON was asked for documentation the 3-step review had been completed for Resident #1's readmission orders on 8/13/24. The DON was unable to provide the 24-hour chart check that was supposed to be completed by night shift, unable to provide the admission checklist verifying the record had been reviewed at morning meeting and when she provided the Medication Review Report that was supposed to be reviewed by the provider, it had never been signed off by the provider. The DON said: Looks like wasn't put in the providers folder. She said there was no documentation that the medication orders had been checked through the 3-step process and/or verified by the provider. On 9/6/24 at 9:00 a.m., the Administrator said he reviewed everything regarding Resident #1 the previous evening. He said Resident #1 came to the facility initially on 7/13/24 and then was sent out again for a feeding tube issue. He said the first round she was with them; she received her daily corticosteroid but, on her return from hospital, it was missed. The Administrator said they will be doing education with all licensed staff about admission orders and medication reconciliation, including the doctors and their extensions. Record review revealed Resident #2 was admitted to the facility on [DATE]. The discharge orders from the hospital included an order for Gabapentin 100 mg cap, take 200 mg by mouth two times daily (medication used to prevent seizures or nerve pain). Record review of Resident #2's MAR for August 2024 shows the order was entered as Gabapentin 100 mg, give 1 tab by mouth two times a day for nerve pain. The 100 mg dose was given twice on 8/17/24, twice on 8/18/24 and once in the morning on 8/19/24. The order was then discontinued on 8/19/24 and changed to Gabapentin 100 mg give 2 capsules by mouth two times a day for nerve pain. Give TWO caps to = 200 mg. No documentation was found in the chart of discussion with the doctor to change dosage or notification to the doctor that Resident #2 had not been receiving the correct prescribed amount of Gabapentin. On 9/6/24 at 9:12 a.m., the DON said she had not been made aware of any discrepancies with medications for Resident #2. She said the initials and the red check mark on the medication reconciliation would mean the medication had been double checked. She said it would have been entered on admission and then the Unit Manager would have checked it the next morning during morning meeting. The DON said she would need to look into it and see what had happened. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105882	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/06/2024

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/6/24 at 1:37 p.m., the DON said after looking into what happened with Resident #2's Gabapentin order she discovered Staff A RN Unit Manager had put in the order and had entered it wrong. The DON said Staff B RN weekend supervisor was the nurse who did the second check, initialed it and did not identify the mistake. The DON said on Monday morning Staff C RN Unit Manager found the mistake and adjusted it but did not notify her and nothing was documented that the doctor was made aware or notified. The DON said with any medication error/variance the doctor should be notified and this notification documented. The DON said all nurses had previously been trained in entering/checking medications and this was an error on all parts that it was overlooked.

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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 - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 prescribers' orders for 2 (Resident #1 and #2) of 3 residents reviewed for medication orders. The findings included: Facility policy Physician Orders 4.3.1 effective October 2021 indicated on page 3: The nurse will review each hard chart for new orders and compare to the electronic order listing report to ensure each written order has been entered into the electronic medical record. If a written physicians order is found on the chart and not on the order listing, transcribe the order and notify the resident/representative. Medication/Treatment variance may be completed if needed with physician notification. Facility Policy titled Event Reporting effective 2019, change date March 2022 indicated: An event report will be completed by the nurse assigned to the resident, for any occurrence outside the routine operational expectation of the facility. This includes but may not be limited to: Medication variance. Events/accidents will be investigated thoroughly, completely and timely. On 9/5/24 at 4:04 p.m., the Director of Nursing (DON) said the process for entering orders when a patient is transferred in from the hospital is: Hospital nurse to facility nurse report is given. Admissions provides nursing with the patients' paperwork prior to admission, which is reviewed, and orders are placed into the electronic chart (PCC). Once the patient arrives at the facility the doctor is contacted for clarification of any medications. Medications are not activated until they speak to the provider. As soon as activated it is sent automatically to pharmacy. The paper chart never gets sent to pharmacy; the only orders they get is what is entered in PCC. Provider will come into building after they've already done a verbal on the phone to review the orders and sign off on the orders. The orders are printed out on a Medication Review Report and put in a folder to be signed off by the provider. DON said there were 3 checks on the medications: you will see a check mark on the medication reconciliation from the hospital which indicates the initial review by nurse that entered the meds in PCC, night shift fills out a form that they did a 24 hour chart check, and in morning meeting all new resident charts are brought to the meeting and gone through one by one and this is documented on admission checklist. Record review revealed that on 8/13/24 Resident #1 returned to the facility after a hospitalization for problems with her feeding tube and aspiration pneumonia. The discharge orders from hospital included an order for Hydrocortisone sodium succinate 100 mg (milligram) injection, inject 20 mg into vein every morning. (corticosteroid medication used to replace the hormone cortisol which the body can no longer produce on its own) (continued on next page)

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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 - Some	Record review of Resident #1's Medication Administration Record (MAR) for August 2024 did not reveal an order for daily hydrocortisone. Instead, it showed an order for Hydrocortisone inject 20 mg intramuscularly one time a day for Aspiration Pneumonia with an order date of 8/13/24 and discontinued on 8/14/24. This intramuscular injection was given one time on 8/14/24. No further hydrocortisone was given to Resident #1 following this injection during this stay. Chart revealed no documentation in nursing progress notes, Advanced Registered Nurse Practitioner (ARNP) notes, or physician notes about discontinuing daily hydrocortisone for Resident #1. Record review of Resident #1's progress notes revealed on 8/27/24 she had a significant decline in condition with projectile vomiting and eventual unresponsiveness with a blood pressure of BP 61/38, Pulse 109, Respiratory Rate of 24, a temp of 102.6 and a mental status evaluation of unresponsiveness. Per progress note dated 8/27/24 at 22:42 Resident #1 was taken to the hospital and was intubated in the Emergency Department. No admitting diagnosis was available at that time. Further progress note on 8/28/24 at 08:24 indicated Resident #1 was admitted with a diagnosis of Adrenal insufficiency related to corticosteroid withdrawal. On 9/5/24 at 10:30 a.m., the DON said she was not aware there had been any concerns regarding Resident #1's hydrocortisone. She agreed Resident #1 had a diagnosis adrenal insufficiency. She reviewed the hospital discharge records and agreed hydrocortisone was ordered daily and reviewed the orders entered at facility. She said it would be the physician who discontinued medications. She agreed there was nothing in the nursing or provider progress notes regarding discontinuing order for daily hydrocortisone. DON said she had been under the impression Resident #1 had been admitted to the hospital for multiple organ failure and was not aware of progress note dated 8/28/24 indicating admission for adrenal insufficiency due to corticosteroid withdrawal. On 9/5/24 at 3:06 p.m., Staff A Registered Nurse (RN) Unit manager said she entered the hospital orders for Resident #1 into the computer. She said the facility does not do intravenous push (IVP) medications. She said she had discussed the hydrocortisone order with the ARNP and received a verbal order for a one-time dose to be given intramuscularly for pneumonia and Staff A discontinued the daily order. She said the only documentation of this would be the entry of the order into PCC. There were no progress notes for either nursing or the ARNP of the discussion of a one-time dose and discontinuance of daily hydrocortisone order. On 9/5/24 at 1:54 p.m., the ARNP said Resident #1 had a history of respiratory distress related to aspiration pneumonia. She said she ordered a one-time dose of intramuscular hydrocortisone related to respiratory distress. ARNP said she did not remember that she had diagnosis of critical adrenal insufficiency or that she was on steroids. ARNP said she was not aware of the hospital order for daily steroids and was not aware Resident #1 did not get steroids beyond 8/14/24. She said the facility never does IV hydrocortisone and that had been policy there for years. ARNP said it was never brought to her attention about the daily order and said it was not something she discontinued. She said had she known about it, she would definitely have put her on a daily oral steroid dose. ARNP said her order for a one-time dose had nothing to do with the daily hydrocortisone order from the hospital, but with pneumonia. (continued on next page)

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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 - Some	On 9/5/24 at 4:04 p.m., the DON was asked for documentation the 3-step review had been completed for Resident #1's readmission orders on 8/13/24. DON was unable to provide 24-hour chart check that was supposed to be completed by night shift, unable to provide the admission checklist verifying the record had been reviewed at morning meeting and when she provided the Medication Review Report that was supposed to be reviewed by the provider, it had never been signed off by the provider. DON said, Looks like wasn't put in the providers folder. She said there was no documentation that the medication orders had been checked through the 3-step process and/or verified by the provider. On 9/6/24 at 9:00 a.m., the Administrator said he reviewed everything regarding Resident #1 the previous evening. He said Resident #1 came to the facility initially on 7/13/24 and then was sent out again for a feeding tube issue. He said the first round she was with them; she received her corticosteroid but, on her return from hospital, it was missed. The Administrator said they will be doing education with all licensed staff about admission orders and medication reconciliation, including the doctors and their extensions. Record review revealed Resident #2 was admitted to the facility on [DATE]. The discharge orders from the hospital included an order for Gabapentin 100 mg cap, take 200 mg by mouth two times daily (medication used to prevent seizures or nerve pain) Record review of Resident #2's MAR for August 2024 shows the order was entered as Gabapentin 100 mg, give 1 tab by mouth two times a day for nerve pain. The 100 mg dose was given twice on 8/17/24, twice on 8/18/24 and once in the morning on 8/19/24. The order was then discontinued on 8/19/24 and changed to Gabapentin 100 mg give 2 capsules by mouth two times a day for nerve pain. Give TWO caps to = 200 mg. No documentation was found in the chart of discussion with the doctor to change dosage or notification to the doctor that Resident #2 had not been receiving the correct prescribed amount of Gabapentin. On 9/6/24 at 9:12 a.m., the DON said she had not been made aware of any discrepancies with medications for Resident #2. She said the initials and the red check mark on the medication reconciliation would mean the medication had been double checked. She said it would have been entered on admission and then the Unit Manager would have checked it the next morning during morning meeting. DON said she would need to look into it and see what had happened. On 9/6/24 at 1:37 p.m., the DON said after looking into what happened with Resident #2's Gabapentin order she discovered Staff A RN Unit Manager had put in the order and had entered it wrong. DON said Staff B RN weekend supervisor was the nurse who did the second check, initialed it and did not identify the mistake. DON said on Monday morning Staff C RN Unit Manager found the mistake and adjusted it but did not notify her and nothing was documented that the doctor was made aware or notified. DON said with any medication error/variance the doctor should be notified and notification documented. DON said all nurses had previously been trained in entering/checking medications and there was an error on all parts that it was overlooked.