STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106055	A. Building B. Wing	09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northwest Florida Community Hospital (Snu)	1360 Brickyard Rd Chipley, FL 32428

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 48176 Based on record review and interview, the facility failed to have accurate Advance Directive information on the medical chart for 2 of 4 residents sampled (Resident #19 and #23). The findings include: Resident #19: Resident #19 was observed to have a No Code sticker on the front of the medical chart. However, Resident #19's face sheet listed the resident as a full code dated 8/5/2024. On 5/19/23, the resident had signed a form saying he wished to be DNR (Do Not Resuscitate). On 09/23/24 at 04:50 PM, during an interview with Staff B, a registered nurse (RN), she was asked what No Code means. Staff B stated that the resident has chosen not to be resuscitated. When asked how new staff would find out the resident's advance directives, Staff B stated they were always instructed to look at the face sheet in the medical chart. On 09/24/24 at 12:21 PM, an interview with the facilities Minimum Data Set (MDS) coordinator was held. When asked about Resident #19's advance directives, the MDS coordinator stated this resident was a DNR. When shown that the record contained conflicting information, the MDS coordinator stated that was done in error. She explained the pharmacy prints out the face sheets and the facility had forgotten to update the pharmacy, so it was showing inaccurate information. The DON was present and was asked how staff would know the advance directives, the DON stated they go by the sticker. She also stated they would correct the discrepancy right away. 50082 Resident #23: The chart for Resident #23 had a sticker stating NO CODE. A Do Not Resuscitate (DNR) form was not found in the chart of Resident #23. The medication administration record (MAR) code status however indicated, FULL CODE. (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: 106055	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/24/2024
NAME OF PROVIDER OR SUPPLIER Northwest Florida Community Hospital (Snu)		STREET ADDRESS, CITY, STATE, ZIP CODE 1360 Brickyard Rd Chipley, FL 32428	

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the advance directives for Resident #23 revealed a document signed on 3/21/24 by the legal representative for Resident #23 which indicated the desire for no resuscitative measures to be taken. On 09/24/24 at approximately 12:25 PM, during an interview with Staff A, the Minimum Data Set coordinator (MDS) stated that Resident 23 was a DNR, NO CODE. She indicated that the FULL CODE printed on the MAR was an error. She stated that the facility had not communicated the correct code status with the pharmacy who is responsible for printing out the MAR.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50082 Based on observations, staff interviews, and record reviews, the facility failed to store and discard medications properly for 3 of 20 patients observed. (Resident #8, #19, and #15) The findings include: Residents #8 and #19: On 09/24/24 at approximately 01:46 PM, an observation of the west hall medication cart revealed expired medications were present for two residents, Resident #8 and Resident #19. For Resident #8, it was observed that Lasix (a medication used to remove assess fluid from the body) 20mg tablets were present, although the tablets had an expiration date on 06/30/2024. A review of the physician's order revealed the medication was ordered on 10/20/2023 and was currently an active order. (photographic evidence obtained) For Resident #19, it was observed that Clonidine 0.1mg tablets for high blood pressure was present, although the packaging stated the tablets had expired on 08/31/2024. A review of the physician's order revealed the medication was ordered on 08/10/2020 and was currently an active order. (photographic evidence obtained) On 09/24/24 at approximately 2:01 PM, during an interview with the director of nursing (DON) and assistant director of nursing (ADON), the DON stated, the night shift nurses check medication expiration dates on the cart daily. I don't know that they check the expirations on the blister packs because they go through them so quickly. The DON also stated, the pharmacist does monthly cart checks for expired medications and completes audit reports. A review of the medication audit report dated 8/13/2024 and 9/17/2024 performed by the Pharmacist revealed, no irregularities, no expired medications for the east medication cart, west medication cart and medication room. A review of the facilities policy labeled Expired Medications revealed, The night shift nurse on duty will monitor the upcoming expiration dates of any medications prescribed to the residents of the skilled nursing unit. The pharmacist provided by Omnicare comes to the facility monthly for routine medication and chart audits. At this time both medication administration carts as well as the medication administration room is assessed for any expired medications by the pharmacist herself. Any expired medications will be removed from the cart/medication room. Routine medications are returned to the prescribing pharmacy (Omnicare). Narcotics are destroyed on site. 45951 Resident #15: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a tour of the facility conducted on 09/23/24 at 12:37 PM, it was observed that Resident #15 had 4 packets of Calmoseptine ointment (this medication is used to prevent skin irritation) and 1 tube of Hydrocortisone cream (this medication is used to treat skin irritation) at their bedside with no staff present. (photographic evidence obtained) During a tour of the facility conducted on 09/24/24 at 10:01 AM, the surveyor observed the Hydrocortisone cream tube was still present along with 2 packets of the Calmoseptine ointment. A review of Resident #15's Quarterly Minimum Data Set, dated dated [DATE], revealed Resident #15 had a Brief Interview of Mental Status score of 5, indicating she had severe cognitive impairment. A review of Resident #15's Medication Administration Record (MAR) revealed there were active physician orders for both medications. However, the Hydrocortisone cream had not been signed off by the staff for the month of September and the Calmoseptine ointment had been signed off only on 09/17/24 and 09/18/24. An interview was conducted with Staff D, a Licensed Practical Nurse, on 09/24/24 at 12:32 PM revealed that she cares for Resident #15 often. Staff D stated she was unaware these medications were present in Resident #15's room. She stated she did not know when the medications were given last but that the Hydrocortisone cream should be kept in the medication cart. She confirmed the Hydrocortisone cream should be given by a nurse. Staff D also confirmed that the nursing staff should be signing off each application of these medications.