

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106075	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/21/2025
NAME OF PROVIDER OR SUPPLIER Garden View Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2180 10th Avenue Vero Beach, FL 32960	
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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404</p> <p>Based on policy review, interview, and record review, the facility failed to ensure timely provision of medications for 2 of 3 sampled residents, as evidenced by the failure to provide insulin and an antibiotic timely upon Resident #1's admission to the facility, and failure to provide insulin timely upon Resident #2's admission to the facility.</p> <p>The findings included:</p> <p>1) Review of the record revealed Resident #1 was admitted to the facility from the hospital on 01/28/25 at 6:00 PM, with diagnoses to include Type 1 Diabetes. Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 15, on a 0 to 15 scale, indicating he was cognitively intact. This MDS also documented the resident received both insulin and an antibiotic during the look-back period of 01/28/25 through 02/01/25.</p> <p>Review of the hospital discharge paperwork documented Resident #1 was to receive insulin, one short-acting and one long-acting, but the paperwork lacked any specific dose or frequency. Further review of the discharge paperwork revealed documentation the resident was to receive Zosyn (an antibiotic), intravenously, every 8 hours.</p> <p>During an interview on 02/21/25 at 11:21 AM, Resident #1 stated it took a long time to get his insulin, upon admission to the facility. The resident stated he thought it was because he was admitted to the facility late in the evening, and they had to get the insulin from an outside pharmacy.</p> <p>Review of the January 2025 Medication Administration Record (MAR) for Resident #1 revealed the following:</p> <p>a) Lantus insulin (long-acting) was ordered to start on 01/29/25 at 6 AM, but was discontinued and not provided.</p> <p>b) A sliding scale insulin regimen with Novolog (short-acting) was ordered to start on 01/29/25 at 7:30 AM with blood sugar checks ordered before each meal and at bedtime but was discontinued and not provided. This order was then initiated on 01/29/25 at 4:30 PM, missing three opportunities for coverage on 01/28/25 at bedtime, 01/29/25 before breakfast, and on 01/29/25 before lunch. This order was initiated nearly 24 hours after admission to the facility. The resident's blood sugar was high at 335 at that time, with a desired blood sugar of less than 200.</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 106075
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>c) Glargine insulin (long-acting) was not started or provided until 01/29/25 at 4:30 PM, nearly 24 hours after admission to the facility. The resident's blood sugar was high at 335 at that time, with a desired blood sugar of less than 200.</p> <p>d) The antibiotic Zosyn was ordered to start on 01/29/25 at 6:00 AM. The Zosyn was not administered at this time, as evidenced by a blank area on the MAR, but started on 01/29/25 at 2 PM, nearly 24 hours after admission to the facility.</p> <p>Review of the progress notes lacked any reason for the lack of medication administration.</p> <p>During a side-by-side record review on 02/21/25, the Assistant Director of Nursing (ADON) confirmed the lack of insulin dosing from the hospital record. The ADON stated the nurse would have had to call the physician to get clarification. The ADON stated that sometimes the issue was with which insulin the insurance would cover, and the pharmacy would then contact the facility for an order to substitute. Upon further review of the orders, the ADON noted the pharmacy had entered an order for the Novolog FlexPen to be administered as per the sliding scale on 01/28/25 at 11:35 PM, and the order was not confirmed by the nursing staff until 01/29/25 at 12:10 PM, fourteen hours later. When asked about the delivery of the FlexPens, the ADON explained the admission or night nurse should have called the physician to get an order to use their stock insulin until the pharmacy delivered the FlexPen. Upon further review of the January 2025 MAR, the ADON agreed Resident #1 did not receive any insulin until 01/29/25 at 4:30 PM, nearly 24 hours after the resident was admitted .</p> <p>During this continued interview, the ADON agreed with the lack of antibiotic administration on 01/29/25 at 6:00 AM. The ADON provided evidence that the Zosyn was available in the facility's stock medications at the time of the survey, although she was unsure if it was available on 01/29/25.</p> <p>During the exit conference on 02/21/25 at approximately 4:45 PM, the Director of Nursing (DON) stated she had reached out to the nurse who should have provided the antibiotic on 01/29/25 at 6 AM, and the nurse would not confirm if she had provided the medication or not.</p> <p>2) Review of the record revealed Resident #2 was admitted to the facility on [DATE] at approximately 9:00 PM, with diagnoses to include Diabetes.</p> <p>Review of the February 2025 MAR for Resident #2 revealed the following:</p> <p>a) Insulin Aspartate (short-acting) was ordered to start on 02/25/25 at 8 AM and not provided.</p> <p>b) Novolog (short-acting) FlexPen was ordered by the pharmacy (as an insurance approved substitute) on 02/14/25 at 11:35 PM. The order was confirmed by nursing staff on 02/15/25 at 12:14 PM, with the first dose administered at that time, 15 hours after admission.</p> <p>c) Insulin Glargine (long-acting) was ordered to start on 02/15/25 at 9 AM and not provided. The pharmacy placed an order for an insurance approved substitute on 02/14/25 at 11:35 PM. The nursing staff confirmed the order on 02/15/25 at 12:16 PM, with the first dose administered at 6 PM, 21 hours after admission.</p> <p>During an interview on 02/21/25 at approximately 4:30 PM, the ADON confirmed the medication delay.</p>		