

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106138	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2024
NAME OF PROVIDER OR SUPPLIER Bridgework on Harden Health and Rehabilitation, LL		STREET ADDRESS, CITY, STATE, ZIP CODE 3110 Oakbridge Blvd E Lakeland, FL 33803	

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 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34768</p> <p>Based on observations, interviews, and record review, the facility failed to provide adequate and timely pain management for two of three sampled residents (#3 and #6).</p> <p>Findings included:</p> <p>1. Resident #3 was admitted on [DATE] and readmitted on [DATE]. Review of the admission record showed diagnoses included but not limited to stage IV sacral pressure ulcer, lumbar spinal stenosis, lumbar wedge compression fracture, diabetes, pain, rheumatoid arthritis with contractures, inflammatory Polyneuropathy, muscle spasms and multiple wounds.</p> <p>Review of the Significant Change, Minimum Data Set (MDS), dated [DATE], showed a Brief Interview for Mental Status (BIMS) score of 13, or cognitively intact. Section GG: Functional Abilities and Goals showed the resident was dependent for toileting and bathing. Section J: Health Conditions showed the resident had occasional pain that occasionally limited his day-to-day activities. He rated his pain 5 on a scale of 1 to 10. Section N: Medications showed he was taking antianxiety, antidepressants, antibiotics, Opioid, and hypoglycemic's.</p> <p>Review of the physician orders, Individual Resident's Controlled Substance Record, and June 2024 Medication Administration Record (MAR) showed:</p> <p>-Oxycodone HCl 15 milligrams (mg) every 12 hours related to pain, as of 06/05/24 to 06/21/2024; pain scale showed pain from 3 to 10 on a scale of 1 to 10; showed pain medication not provided on 06//17/24 p.m. dose, 06/18/24 both doses, 06/19/24 both doses, 06/20/24 both doses, and 06/21/24 both doses.</p> <p>-Oxycodone HCL 5 mg every 6 hours as needed for pain as of 06/05/2024</p> <p>Review of the progress notes- including the e-mar notes- showed the following:</p> <p>On 06/18/24 at 0811, Oxycodone HCl 15 mg for pain; Staff C, PCP (Primary Care Physician) / MD (Medical Director) made aware of new script needed. PRN (as needed) Oxycodone 5 mg administered.</p> <p>On 06/18/24 at 1904, Oxycodone 5 mg prn given, follow up pain was a 4.</p> <p>On 06/19/24 at 0315, Oxycodone 5 mg prn given, follow up pain was a 5.</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
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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 06/19/24 at 0956, Oxycodone 15 mg for pain. Awaiting script from Staff C, PCP/MD. Patient comfortable at this time.</p> <p>On 06/19/24 at 1645, Oxycodone 5 mg prn given, medication was ineffective. Per the resident it does not help and follow-up pain was a 9.</p> <p>On 06/19/24 at 1650, Alprazolam 0.5 mg as needed for anxiety was given. It was ineffective. Per the resident, it does not help, my pain is now a 9</p> <p>On 06/19/24 at 1812, dietary note showed weight down 2 pounds. Resident has pain that can alter po intake.</p> <p>On 06/19/24 at 2035, Oxycodone 15 mg every 12 hours; Awaiting delivery of Oxycodone 15.</p> <p>On 06/19/24 at 2141, Oxycodone 5 mg prn given, follow-up pain was a 5.</p> <p>On 06/20/24 at 0836, Oxycodone 15 mg every 12 hours. Pharmacy is awaiting script from Staff C, PCP/MD.</p> <p>On 06/20/24 at 1508, Tylenol 325 mg x 2 tabs given, ineffective. Follow-up pain was a 8.</p> <p>On 06/20/24 at 2017, Oxycodone 15 mg every 12 hours. Medication unavailable in the Emergency Drug Kit. Staff C, PCP/MD was notified and awaiting new script for medication. Offered resident prn Oxycodone and resident accepted.</p> <p>On 06/21/24 at 0757, Oxycodone 5 mg prn given. Follow-up pain of a 5.</p> <p>On 06/21/24 at 0933, Oxycodone 15 mg every 12 hours. need a new script, Staff C, PCP/MD notified.</p> <p>On 06/21/24 at 2042, Oxycodone 15 mg two times a day, shown given. Individual Resident's Controlled Substance Record showed medication not given until 06/22/24 at 1000.</p> <p>Review of the care plans showed the following:</p> <p>-Resident #3 had chronic pain related to history of a motor vehicle collision. He had a lumbar one fracture, muscle spasms, Polyneuropathy, severe stenosis and had a L3- S1 spinal fusion on 01/18/23. He was alert and oriented x 3 and was able to make his needs known. He had rheumatoid arthritis. He had multiple skin issues including pressure / diabetic / trauma.</p> <p>(continued on next page)</p>

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-He now has Hospice. Care plan initiated on 03/08/2024 and updated on 07/02/2024. Interventions included but not limited to new medication added routine as of 07/10/2024; Administer analgesia as per orders as of 03/08/2024. Anticipate the resident's need for pain relief and respond immediately to any complaint of pain as of 03/08/2024. Medications have been adjusted as of 04/25/2024. Monitor/document for probable cause of each pain episode. Remove/limit causes where possible as of 03/08/2024. Monitor/record/report to Nurse any signs and symptoms of non-verbal pain as of 03/08/2024. Monitor/record/report to nurse loss of appetite, refusal to eat and weight loss as of 03/08/2024. Monitor/record/report to Nurse resident complaints of pain or requests for pain treatment as of 03/08/2024. Notify physician/ Hospice if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain as of 03/08/2024. Observe and report changes in usual routine, sleep patterns, decrease in functional abilities, decrease ROM, withdrawal or resistance to care as of 03/08/2024.</p> <p>-Care plans showed Resident #3 had an alteration in musculoskeletal status related to motor vehicle collision. He had L1 fracture, severe stenosis and had a L3-S1 spinal fusion on 01/18/2023. He also has rheumatoid arthritis, Rhabdomyolysis, osteopenia, chronic back pain as of 03/04/2024. Interventions included but not limited to give analgesics as ordered by the physician. Monitor an document for side effects and effectiveness as of 03/08/2024.</p> <p>-Care plans showed Resident #3 had rheumatoid arthritis, muscle spasms, spinal stenosis, spondylopathy, compression fractures, osteopenia as of 04/25/2024. Interventions included but not limited to give analgesics as ordered by the physician. Monitor an document for side effects and effectiveness as of 04/25/2024.</p> <p>During an interview and observation on 07/11/2024 at 9:55 a.m. Resident #3 was sitting in bed with the head slightly elevated. He stated he has had no problems with pain or pain medications. He stated he gets them, on schedule and as needed, if he asks for it.</p> <p>During an interview on 07/11/2024 at 10:05 a.m. with Staff A, Licensed Practical Nurse (LPN), Resident #3's nurse for the day. Staff</p> <p>A stated the resident was on Hospice now and they were controlling his pain medications. He had multiple wounds and was seen by the wound care doctor. He has wounds on his bottom, left and right hip, and feet. She stated she had seen his wounds, and they were getting better. He had chronic pain and Hospice was caring for that. She stated he was on scheduled pain medications, and he can ask for his prn pain meds. Staff A also stated he was on meds for anxiety. She stated the resident will use the call light or yell when he wants his prn pain meds. Staff A, LPN stated he had been out of his pain medications once. She stated the doctor was called for a script and the doctor has to send a script to the pharmacy. Staff A, stated, they call the pharmacy to follow-up.</p> <p>2. Resident #6 was admitted on [DATE]. Review of the admission record showed diagnoses included but were not limited to Multiple Sclerosis, dorsalgia, muscle weakness, sacral pressure ulcers, pain.</p> <p>Review of the quarterly MDS dated [DATE] showed a BIMs score of 12 (cognitively intact). Section GG, Functional Abilities and Goals showed the resident was dependent for toileting and bathing. Section J, Health Conditions showed the resident had occasional pain. Rated 5 on the scale of 1 to 10. Section N, Medications showed resident was on antianxiety, antidepressant, anticoagulant and Opioid.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the physician orders, Individual Resident's Controlled Substance Record and June 2024 Medication Administration Record (MAR) showed:</p> <p>Fentanyl Transdermal Patch 72 hours 100 mcg/hr, apply patch transdermally every 72 hours related to Multiple Sclerosis as of 11/29/2023. The last Fentanyl patch was applied on 06/14/2024 at 1000. Fentanyl patch was not applied on 06/17/24 at 1000. It was not applied until 06/20/2024 at 1010.</p> <p>Review of the Progress notes showed</p> <p>On 06/17/2024 at 1004, Fentanyl patch 72-hour 100 mcg/hour. Staff C, PCP/MD notified to send script to pharmacy. Staff C, PCP/MD notified that pharmacy is in need of a new script.</p> <p>Review of the care plans showed Resident #6 had chronic pain, dorsalgia and multiple sclerosis as of 11/27/2023 and was updated on 05/23/2024. The goal was for the resident to not have discomfort related to side effects of analgesia and will not have an interruption in normal activities. Interventions included but were not limited to administer analgesia as per orders as of 11/27/2023. Anticipate the resident's need for pain relief and respond immediately to any complaint of pain as of 11/27/2023. Monitor/document for side effects of pain medication. Report occurrences to the physician as of 11/27/2023. Monitor/record pain characteristics and PRN revised on 11/27/2023. Monitor/record/report to Nurse any signs and symptoms of non-verbal pain as of 11/27/2023. Monitor/record/report to nurse any complaints of pain or requests for pain treatment as of 11/27/2023. Notify physician if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain as of 11/2/2023.</p> <p>During an interview and observation on 07/11/2024 at 3:55 p.m. Resident #6 was lying in bed. He was difficult to understand during the interview. He stated he was in pain, his head and neck. He had pain medication at 1408 per his floor nurse. The nurse stated the Hospice nurse had been there last night and was addressing the resident's pain.</p> <p>An interview occurred on 07/11/2024 at 3:00 p.m. with the Director of Nursing (DON) and the Nursing Home Administrator (NHA). The DON stated it was the process to perform a narcotic audit every Wednesday for the need to renew prescriptions. The</p> <p>(continued on next page)</p>		

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