

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35960928	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/16/2025
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NAME OF PROVIDER OR SUPPLIER WEST DELRAY NURSING & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 16200 S JOG ROAD DELRAY BEACH, FL 33446
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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{N 000} INITIAL COMMENTS

An unannounced revisit to Relicensure survey was conducted on _____ at West Delray Nursing and Rehabilitation Center. The previously cited deficiencies were not found corrected at the time of the survey.

{N 000}

{N 054} SS=D 59A-4.107(5), FAC Follow Physician Orders

All physician orders must be followed as prescribed, and if not followed, the reason must be recorded on the resident's medical record during that shift.

{N 054}

This Statute or Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure that physician orders were followed allowing the medication error rate to be 5% or greater. The medication error rate was 32%. (Ten) 10 medication errors were identified while observing a total of 31 opportunities, affecting Resident #2, Resident #3, Resident #5 and Resident #6.

The findings included:

Record review of facility's policy, titled, Administration of Drugs, dated _____, documented, "Drugs will be administered in a timely manner ...drugs ...must be administered within one (1) hour before or after their prescribed time ...".

Review of the facility's plan of correction included a "Medication Pass Observation" record dated _____ signed by the Consultant Pharmacist for Staff A, Licensed Practical Nurse (LPN). Review of the facility's plan of correction included a "Medication Pass Observation" record dated _____ signed by the Consultant Pharmacist for

(1) Actions taken to correct the deficient practice:

Resident #2 was evaluated on _____ by the Unit Manager. There have been no ill effects noted from the medication errors. The physician and family were notified. The resident remains at the facility and is stable.

Resident #3 was evaluated on _____ by the Unit Manager for any side effects due to medication timing and administration errors and none observed. The physician and resident family were notified. The resident remains at the facility and is stable.

Resident #5 was evaluated on _____ by the Unit Manager for any side effects due to medication timing and administration errors and none observed. The physician and resident family were notified. The resident remains at the facility and is stable.

AHCA Form 3020-0001
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Electronically Signed

TITLE

(X8) DATE

/25

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{N 054}	<p>Continued From page 1</p> <p>Staff C, LPN. Review of Staff B's, LPN, "Agency Orientation Checklist", signed on _____, documented the staff completed orientation to medication and treatment guidelines.</p> <p>1. Review of the WebMD website article, titled, "_____- Uses, Side Effects, and More", documented, "How to use _____: Swallow _____-coated tablets whole. Do not crush or chew _____-coated tablets. Doing so can increase _____ upset...".</p> <p>Review of Resident #2's clinical record documented an admission on _____ with no readmissions, with diagnoses that included _____ and _____ following a _____, and _____.</p> <p>Review of Resident #2's physician orders dated _____ documented an order that included: a. _____ oral tablet Chewable 81 mg (milligrams) give by _____ one time a day for [_____] prophylaxis.</p> <p>On _____ at 10:04 AM, medication administration observation for Resident #2 was started and performed by Staff A, LPN. Staff A proceeded to prepare medications that included: _____ 81 mg (milligrams) (_____), _____ 100 mg tablet, _____ 2 mg, _____ 24-26 mg, _____ 500 mg, _____ 75 mg, and _____ 3.125 mg. Staff A stated he separated the _____ tablet from the rest of the meds because it was a chewable medication.</p> <p>On _____ at 10:11 AM, observation revealed Staff A entered Resident #2's room, performed _____ sanitation and assisted the resident with the medications (meds). Staff A then handed the</p>	{N 054}	<p>Resident #6 was evaluated on _____ by the Unit Manager for any side effects due to medication timing and administration errors and none observed. The physician and resident family were notified. The resident remains at the facility and is stable.</p> <p>Staff A received re-education on _____ by ADON on administering medications as per physician orders and notification to supervisor and/or physician if medications may be administered outside of scheduled time frame.</p> <p>Staff B received re-education on _____ by ADON on administering medications as per physician orders and notification to supervisor and/or physician if medications may be administered outside of scheduled time frame.</p> <p>Staff C received re-education on _____ by ADON on administering medications as per physician orders and notification to supervisor and/or physician if medications may be administered outside of scheduled time frame.</p> <p>Staff E received re-education on monitoring the timeliness of medication administration and facility process to follow specific to timeliness of medication administration on _____ by ADON.</p> <p>(2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken:</p>	
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{N 054}	<p>Continued From page 2</p> <p>resident the medication cup with the _____ tablet and told the resident to chew it and not to swallow it. Observation revealed the resident swallowed the _____ medication.</p> <p>An interview and a side-side review of Resident #2's physician orders for the _____ was conducted with Staff A who stated the order was for chewable _____. Staff A retrieved the _____ bottle from the cart and confirmed he gave the resident's _____ tablet rather than a chewable tablet as prescribed. Observation revealed there was a bottle of _____ chewable in the medication cart.</p> <p>On _____ at 2:50 PM, an interview was conducted with Staff A who stated he has been working in the facility since _____ day shift from 7:00 AM to 3:30 PM. Staff A stated he attended an in-service related to medication administration more than once. Staff A was asked what he learned from the in-service and stated that they need to give the medication around the clock and if unable to do so, notify the doctor. Staff A was asked if the in-service involved administering medications timely. He replied that the medications need to be given one (1) hour before and one (1) hour after the scheduled time. Staff A stated medications need to be given on time.</p> <p>2. Review of Resident #3's clinical record documented an admission on _____ with no readmissions, with diagnoses that included _____ of _____, Adult _____ and _____.</p> <p>Review of Resident #3's physician orders documented prescribed medications that included:</p>	{N 054}	<p>Facility review of medication administration was conducted on _____ by the Director of Nursing/designee. Physician notification was completed on concerns identified and new orders obtained and followed. Ad hoc QAPI meeting was held on _____ with members of the Interdisciplinary Team and the facility Medical Director to determine Root Cause of the untimely medication administration. Education to begin on a Person Centered Medication Administration Program.</p> <p>(3) What measures will be put into place or what systematic changes will be made to ensure that the practice does not recur:</p> <p>Licensed Nursing Staff were re-educated on _____ to _____ by the Director of Nursing Services/designee on the Person Centered Medication Administration Program with an emphasis on timely medication administration, notification to supervisor and/or physicians as indicated and following physician orders for medication administration. Medication Administration post test and competency completed to address the six rights of medication administration including right form and right time of administration. Newly hired staff will receive this education during new hire orientation. Agency staff will receive this education prior to working a shift.</p> <p>(4) How the corrective actions will be monitored to ensure the practice will not recur:</p>	

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**16200 S JOG ROAD
DELRAY BEACH, FL 33446**

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{N 054}	<p>Continued From page 3</p> <p>a. Oral Tablet 5 MG () Give 3 tablet by three times a day for dated .</p> <p>b. Oral Capsule 2.5 MG () Give 1 capsule by two times a day for Appetite Stimulant dated /025.</p> <p>On at 10:31 AM, medication administration observation for Resident #3 was started and performed by Staff B, LPN. Staff B proceeded to prepare medications that included: 5 mg (3 tablets). Staff B stated the resident declined the medication.</p> <p>On at 10:43 AM, observation revealed Staff B entered Resident #3's room and assisted the resident with his medication administration. Staff B returned to the medication cart to document the resident's medication administration. Observation revealed Resident #3's e-MAR (electronic medication administration record) screen red in color. An interview was conducted with Staff B who stated the red screen indicated "late ...time passed", and added the resident medications were scheduled for 9:00 AM and she was late. Staff B was asked why she was late and stated, "everybody comes to the cart, and tell me to do this or do that". Staff B stated she spent a lot of time with a resident who lost his and , and they could not find them, and he was going home today. Staff B stated she had 30 residents assigned to her and had about 15 more residents to do medication administration for. Staff B was asked if she informed the Unit Manager of her been late to administer medication for the 15 residents and stated she had not done so. Staff B stated she had come to the building (facility) before on and off and was at the facility on .</p>	{N 054}	<p>The Director of Nursing Services and/or designee will conduct weekly quality review of 5 staff during medication administration to ensure medications are being administered timely and as prescribed by the physician weekly x 4 weeks, and then every 2 weeks x 2 months to ensure medication is administered per pharmacy package directions on the medication. The findings of these quality reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly until committee determines substantial compliance has been met and recommends moving to quarterly monitoring by the Regional Director of Clinical Services when completing their systems review.</p>	
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{N 054}	<p>Continued From page 4</p> <p>Review of Resident #3's "Medication Admin Audit Report" documented the resident received his 9:00 AM scheduled medications including tablet at 10:50 AM. The next dose of was scheduled for 1:00 PM.</p> <p>3. Review of Resident #5's clinical record documented an admission on with no readmissions, with diagnoses that included of the Insufficiency and (, along the path of a or).</p> <p>Review of Resident #5's physician orders documented the prescribed medications that included:</p> <p>a. Extended Capsule 100 MG Give 2 capsules by one time a day for dated</p> <p>b. Extended Capsule 100 MG Give 3 capsule by at bedtime for dated</p> <p>c. Tablet 5 MG Give 0.5 tablet by one time a day for Hold for () < 120 dated</p> <p>On at 11:05 AM, during an interview and a side-by-side review with Staff C, Resident #5's e-MAR screen revealed a red color instead of a green color. Staff C stated it was red because the resident's medication administration was late. Staff C was asked why she was late and stated because she had 29 residents, had to do skin care, answer call lights, and talk to family on the phone when they call and had to call the doctors. Staff C was asked if she had communicated with her supervisor about been late with the medications administration and replied, "they know".</p>	{N 054}		

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{N 054}	<p>Continued From page 5</p> <p>On _____ at 11:11 AM, medication administration observation for Resident #5 was started and performed by Staff C. Staff C entered the resident's room and check the resident's vital signs and stated she would hold the resident's _____ because of a low _____. Staff C returned to the medication cart and proceeded to prepare medications that included:</p> <p>a. _____ ER 100 mg two (2) capsules</p> <p>On _____ at 11:23 AM, observation revealed Staff C entered the resident's room and assisted Resident #5 with the medication administration. Staff C was asked the scheduled time for the medications the resident received and stated the medications were scheduled for 9:00 AM. Staff C stated the _____ was scheduled for twice a day.</p> <p>On _____ at 2:48 PM, an interview was conducted with Staff C who stated she attended a medication administration in-service and that medications can be given one hour before or after scheduled time. Staff C stated management was aware of the nurses being late with the administration of medications. Staff C stated she did a medication administration pass with the Consultant Pharmacist.</p> <p>Review of Resident #5's "Medication Admin Audit Report" documented the resident received her 9:00 AM scheduled medications at 11:29 AM including _____ Extended Capsule. The resident's _____ Extended Capsule next dose was scheduled for 9:00 PM.</p> <p>4. Review of Resident #6's clinical record documented an admission on _____ with no readmissions with diagnoses that included _____</p>	{N 054}		

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{N 054}	<p>Continued From page 6</p> <p>and</p> <p>On at 11:33 AM, an interview was conducted with Staff B, LPN, who stated she had to do checks now, and when asked if she was finished with the 9:00 AM scheduled medication administration, replied she had not and will do them together.</p> <p>Review of Resident #6's physician orders documented the prescribed medications that included:</p> <p>a. Oral Tablet 500 MG () Give 2 tablet by three times a day for, dated</p> <p>b. Oral Tablet 5 MG () Give 1 tablet by three times a day for dated</p> <p>c. Oral Tablet 325 (65) MG () Give 1 tablet by two times a day for date</p> <p>d. Oral Tablet 20 MG () Give 1 tablet by two times a day for () dated</p> <p>e. Oral Tablet 1000 MG () Give 1 tablet by two times a day for dated</p> <p>f. Oral Tablet 5 MG () Give 1 tablet by two times a day for</p> <p>g. Pregabalin Oral Capsule 75 MG (Pregabalin) Give 1 capsule by three times a day for dated</p> <p>On at 11:39 AM, a medication administration observation for Resident #6 was started and performed by Staff B, LPN. Staff B proceeded to prepare medications that included:</p> <p>a. 500 mg (2 tabs)</p> <p>b. 5 mg</p>	{N 054}		

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{N 054}	<p>Continued From page 7</p> <p>c. 325 (65) mg d. 20 mg e. 1000 mg f. Pregabalin 75 mg (a controlled substance).</p> <p>On at 12:05 PM, observation revealed Staff B entered the resident's room and assisted the resident with the medications administration. At 12:09 PM, observation revealed Staff B returned to the medication cart and signed off the medications administered at the time. An interview was conducted with Staff B who stated she had about five more residents left for 9:00 AM medication administration.</p> <p>Review of Resident #6's "Medication Admin Audit Report" documented the resident received his 9:00 AM scheduled medications at 12:08 PM.</p> <p>Review of Resident #6's Medication Administration Record (MAR) documented 500 mg, Pregabalin 75 mg, and 5 mg next dose was scheduled for 1:00 PM. Resident #6's 325 mg, 20 mg, 5 mg and 1000 mg next dose was scheduled for 5:00 PM.</p> <p>On at 2:54 PM, an interview was conducted with Staff B who stated she had orientation to the facility during COVID and had been coming to the facility since 2023. Today her shift started at 7:00 AM. The LPN was asked when she would administer the medications scheduled for 9:00 AM and stated, between 9:00 AM and 11:00 AM.</p> <p>On at 3:05 PM, an interview was conducted with Staff E, Unit Manager, who was asked what they were doing to help those nurses having a hard time administering the resident's</p>	{N 054}		
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{N 054}	<p>Continued From page 8</p> <p>medication timely. Staff E stated they were in-servicing the staff on time management. She was asked if she was aware that at 11:00 AM, Staff B had 15 residents left to be given their 9:00 AM medications; Staff E opened her _____ wide and put her _____ down; Staff E stated she went to help her after surveyor did the medication pass. Staff E was apprised that by 12:08 PM, she still had 5 more residents to administer morning medications. Staff E stated the resident's physician was notified.</p> <p>On _____ at 3:25 PM, an interview was conducted with the Director of Nursing (DON) who was apprised of medication administration observation's findings. The DON stated that an Agency Nurse is expected to do administration of medications timely.</p> <p>Class III</p>	{N 054}		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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{F 000}	INITIAL COMMENTS An unannounced revisit to the Recertification survey was conducted on _____ at West Delray Nursing and Rehabilitation Center. The facility is not in compliance with 42 CFR 483 Requirements for Long Term Care Facilities. Previously cited deficiencies were not found corrected.	{F 000}			
{F 759} SS=D	Free of Medication Error Rts 5 Pront or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure that the medication error rate was not 5% or greater. The medication error rate was 32%. (Ten) 10 medication errors were identified while observing a total of 31 opportunities, affecting Resident #2, Resident #3, Resident #5 and Resident #6. The findings included: Record review of facility's policy, titled, Administration of Drugs, dated _____, documented, "Drugs will be administered in a timely manner ...drugs ...must be administered within one (1) hour before or after their prescribed time ...". Review of the facility's plan of correction included a "Medication Pass Observation" record dated _____ signed by the Consultant Pharmacist for	{F 759}	(1) Actions taken to correct the deficient practice: Resident #2 was evaluated on _____ by the Unit Manager. There have been no ill effects noted from the medication errors. The physician and family were notified. The resident remains at the facility and is stable. Resident #3 was evaluated on _____ by the Unit Manager for any side effects due to medication timing and administration errors and none observed. The physician and resident family were notified. The resident remains at the facility and is stable. Resident #5 was evaluated on _____ by the Unit Manager for any side effects due		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

/2025

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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{F 759}	<p>Continued From page 1</p> <p>Staff A, Licensed Practical Nurse (LPN). Review of the facility's plan of correction included a "Medication Pass Observation" record dated _____ signed by the Consultant Pharmacist for Staff C, LPN.</p> <p>Review of Staff B's, LPN, "Agency Orientation Checklist", signed on _____, documented the staff completed orientation to medication and treatment guidelines.</p> <p>1. Review of the WebMD website article, titled, "_____- Uses, Side Effects, and More", documented, "How to use _____: Swallow _____-coated tablets whole. Do not crush or chew _____-coated tablets. Doing so can increase _____ upset...".</p> <p>Review of Resident #2's clinical record documented an admission on _____ with no readmissions, with diagnoses that included _____ and _____ following a _____, and _____, and _____.</p> <p>Review of Resident #2's physician orders dated _____ documented an order that included: a. _____ oral tablet Chewable 81 mg (milligrams) give by _____ one time a day for [_____] prophylaxis.</p> <p>On _____ at 10:04 AM, medication administration observation for Resident #2 was started and performed by Staff A, LPN. Staff A proceeded to prepare medications that included: _____, 81 mg (milligrams) (_____), _____, 100 mg tablet, _____ 2 mg, _____ 24-26 mg, _____ 500 mg, 75 mg, and _____ 3.125 mg. Staff A stated he separated the _____ tablet from the rest of the meds because it was a chewable medication.</p>	{F 759}	<p>to medication timing and administration errors and none observed. The physician and resident family were notified. The resident remains at the facility and is stable.</p> <p>Resident #6 was evaluated on _____ by the Unit Manager for any side effects due to medication timing and administration errors and none observed. The physician and resident family were notified. The resident remains at the facility and is stable.</p> <p>Staff A received re-education on _____ by ADON administering medications as per physician orders and notification to supervisor and/or physician if medications may be administered outside of scheduled time frame.</p> <p>Staff B received re-education on _____ by ADON administering medications as per physician orders and notification to supervisor and/or physician if medications may be administered outside of scheduled time frame.</p> <p>Staff C received re-education on _____ by ADON administering medications as per physician orders and notification to supervisor and/or physician if medications may be administered outside of scheduled time frame.</p> <p>Staff E received re-education on _____ monitoring the timeliness of medication administration and facility process to follow specific to timeliness of medication</p>		

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{F 759}	<p>Continued From page 2</p> <p>On _____ at 10:11 AM, observation revealed Staff A entered Resident #2's room, performed sanitation and assisted the resident with the medications (meds). Staff A then handed the resident the medication cup with the _____ tablet and told the resident to chew it and not to swallow it. Observation revealed the resident swallowed the _____ medication.</p> <p>An interview and a side-side review of Resident #2's physician orders for the _____ was conducted with Staff A who stated the order was for chewable _____. Staff A retrieved the _____ bottle from the cart and confirmed he gave the resident's _____ tablet rather than a chewable tablet as prescribed. Observation revealed there was a bottle of _____ chewable in the medication cart.</p> <p>On _____ at 2:50 PM, an interview was conducted with Staff A who stated he has been working in the facility since _____, day shift from 7:00 AM to 3:30 PM. Staff A stated he attended an in-service related to medication administration more than once. Staff A was asked what he learned from the in-service and stated that they need to give the medication around the clock and if unable to do so, notify the doctor. Staff A was asked if the in-service involved administering medications timely. He replied that the medications need to be given one (1) hour before and one (1) hour after the scheduled time. Staff A stated medications need to be given on time.</p> <p>2. Review of Resident #3's clinical record documented an admission on _____ with no readmissions, with diagnoses that included _____ of _____, Adult Failure to</p>	{F 759}	<p>administration on _____ by ADON.</p> <p>(2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken:</p> <p>Facility review of medication administration was conducted on _____ by the Director of Nursing/designee. Physician notification was completed on concerns identified and new orders obtained and followed. Ad hoc QAPI meeting was held on _____ with members of the Interdisciplinary Team and the facility Medical Director to determine Root Cause of the untimely medication administration. Education to begin on a Person Centered Medication Administration Program.</p> <p>(3) What measures will be put into place or what systematic changes will be made to ensure that the practice does not recur:</p> <p>Licensed Nursing Staff were re-educated on _____ to _____ by the Director of Nursing Services/designee on the Person Centered Medication Administration Program with an emphasis on timely medication administration, notification to supervisor and/or physicians as indicated and following physician orders for medication administration. Medication Administration post test and competency completed to address the six rights of medication administration including right form and right time of administration. Newly hired staff will receive this</p>	

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{F 759}	Continued From page 3 and Review of Resident #3's physician orders documented prescribed medications that included: a. Oral Tablet 5 MG () Give 3 tablet by three times a day for dated b. Oral Capsule 2.5 MG () Give 1 capsule by two times a day for Appetite Stimulant dated /025. On at 10:31 AM, medication administration observation for Resident #3 was started and performed by Staff B, LPN. Staff B proceeded to prepare medications that included: 5 mg (3 tablets). Staff B stated the resident declined the medication. On at 10:43 AM, observation revealed Staff B entered Resident #3's room and assisted the resident with his medication administration. Staff B returned to the medication cart to document the resident's medication administration. Observation revealed Resident #3's e-MAR (electronic medication administration record) screen red in color. An interview was conducted with Staff B who stated the red screen indicated "late ...time passed", and added the resident medications were scheduled for 9:00 AM and she was late. Staff B was asked why she was late and stated, "everybody comes to the cart, and tell me to do this or do that". Staff B stated she spent a lot of time with a resident who lost his and , and they could not find them, and he was going home today. Staff B stated she had 30 residents assigned to her and had about 15 more residents to do medication	{F 759}	education during new hire orientation. Agency staff will receive this education prior to working a shift. (4) How the corrective actions will be monitored to ensure the practice will not recur: The Director of Nursing Services and/or designee will conduct weekly quality review of 5 staff during medication administration to ensure medications are being administered timely and as prescribed by the physician weekly x 4 weeks, and then every 2 weeks x 2 months to ensure medication is administered per pharmacy package directions on the medication. The findings of these quality reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly until committee determines substantial compliance has been met and recommends moving to quarterly monitoring by the Regional Director of Clinical Services when completing their systems review.	

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{F 759}	<p>Continued From page 4</p> <p>administration for. Staff B was asked if she informed the Unit Manager of her been late to administer medication for the 15 residents and stated she had not done so. Staff B stated she had come to the building (facility) before on and off and was at the facility on</p> <p>Review of Resident #3's "Medication Admin Audit Report" documented the resident received his 9:00 AM scheduled medications including tablet at 10:50 AM. The next dose of was scheduled for 1:00 PM.</p> <p>3. Review of Resident #5's clinical record documented an admission on with no readmissions, with diagnoses that included of the Insufficiency and (, along the path of a or).</p> <p>Review of Resident #5's physician orders documented the prescribed medications that included:</p> <p>a. Extended Capsule 100 MG Give 2 capsules by one time a day for dated</p> <p>b. Extended Capsule 100 MG Give 3 capsules by at bedtime for dated</p> <p>c. Tablet 5 MG Give 0.5 tablet by one time a day for Hold for () < 120 dated</p> <p>On at 11:05 AM, during an interview and a side-by-side review with Staff C, Resident #5's e-MAR screen revealed a red color instead of a green color. Staff C stated it was red because the resident's medication administration was late. Staff C was asked why she was late and stated</p>	{F 759}			

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{F 759}	<p>Continued From page 5</p> <p>because she had 29 residents, had to do skin care, answer call lights, and talk to family on the phone when they call and had to call the doctors. Staff C was asked if she had communicated with her supervisor about been late with the medications administration and replied, "they know".</p> <p>On at 11:11 AM, medication administration observation for Resident #5 was started and performed by Staff C. Staff C entered the resident's room and check the resident's vital signs and stated she would hold the resident's signs because of a low . Staff C returned to the medication cart and proceeded to prepare medications that included:</p> <p>a. ER 100 mg two (2) capsules</p> <p>On at 11:23 AM, observation revealed Staff C entered the resident's room and assisted Resident #5 with the medication administration. Staff C was asked the scheduled time for the medications the resident received and stated the medications were scheduled for 9:00 AM. Staff C stated the was scheduled for twice a day.</p> <p>On at 2:48 PM, an interview was conducted with Staff C who stated she attended a medication administration in-service and that medications can be given one hour before or after scheduled time. Staff C stated management was aware of the nurses being late with the administration of medications. Staff C stated she did a medication administration pass with the Consultant Pharmacist.</p> <p>Review of Resident #5's "Medication Admin Audit Report" documented the resident received her</p>	{F 759}		

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{F 759}	<p>Continued From page 6</p> <p>9:00 AM scheduled medications at 11:29 AM including Extended Capsule. The resident's Extended Capsule next dose was scheduled for 9:00 PM.</p> <p>4. Review of Resident #6's clinical record documented an admission on _____ with no readmissions with diagnoses that included _____ and _____.</p> <p>On _____ at 11:33 AM, an interview was conducted with Staff B, LPN, who stated she had to do _____ checks now, and when asked if she was finished with the 9:00 AM scheduled medication administration, replied she had not and will do them together.</p> <p>Review of Resident #6's physician orders documented the prescribed medications that included:</p> <p>a. _____ Oral Tablet 500 MG (_____) Give 2 tablet by _____ three times a day for _____ dated _____</p> <p>b. _____ Oral Tablet 5 MG (_____) Give 1 tablet by _____ three times a day for _____ dated _____</p> <p>c. _____ Oral Tablet 325 (65 _____) MG (_____) Give 1 tablet by _____ two times a day for _____ date _____</p> <p>d. _____ Oral Tablet 20 MG (_____) Give 1 tablet by _____ two times a day for (_____) dated _____</p> <p>e. _____ Oral Tablet 1000 MG (_____) Give 1 tablet by _____ two times a day for _____ dated _____</p> <p>f. _____ Oral Tablet 5 MG (_____) Give 1 tablet by _____ two times a day for _____</p>	{F 759}			

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{F 759}	<p>Continued From page 7</p> <p>g. Pregabalin Oral Capsule 75 MG (Pregabalin) Give 1 capsule by three times a day for dated</p> <p>On at 11:39 AM, a medication administration observation for Resident #6 was started and performed by Staff B, LPN. Staff B proceeded to prepare medications that included:</p> <p>a. 500 mg (2 tabs) b. 5 mg c. 325 (65) mg d. 20 mg e. 1000 mg f. Pregabalin 75 mg (a controlled substance).</p> <p>On at 12:05 PM, observation revealed Staff B entered the resident's room and assisted the resident with the medications administration. At 12:09 PM, observation revealed Staff B returned to the medication cart and signed off the medications administered at the time. An interview was conducted with Staff B who stated she had about five more residents left for 9:00 AM medication administration.</p> <p>Review of Resident #6's "Medication Admin Audit Report" documented the resident received his 9:00 AM scheduled medications at 12:08 PM.</p> <p>Review of Resident #6's Medication Administration Record (MAR) documented 500 mg, Pregabalin 75 mg, and 5 mg next dose was scheduled for 1:00 PM. Resident #6's 325 mg, 20 mg, 5 mg and 1000 mg next dose was scheduled for 5:00 PM.</p> <p>On at 2:54 PM, an interview was conducted with Staff B who stated she had</p>	{F 759}			

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{F 759}	Continued From page 8 orientation to the facility during COVID and had been coming to the facility since 2023. Today her shift started at 7:00 AM. The LPN was asked when she would administer the medications scheduled for 9:00 AM and stated, between 9:00 AM and 11:00 AM. On at 3:05 PM, an interview was conducted with Staff E, Unit Manager, who was asked what they were doing to help those nurses having a hard time administering the resident's medication timely. Staff E stated they were in-servicing the staff on time management. She was asked if she was aware that at 11:00 AM, Staff B had 15 residents left to be given their 9:00 AM medications; Staff E opened her , wide and put her down; Staff E stated she went to help her after surveyor did the medication pass. Staff E was apprised that by 12:08 PM, she still had 5 more residents to administer morning medications. Staff E stated the resident's physician was notified. On at 3:25 PM, an interview was conducted with the Director of Nursing (DON) who was apprised of medication administration observation's findings. The DON stated that an Agency Nurse is expected to do administration of medications timely.	{F 759}			
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and	F 867			

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F 867	<p>Continued From page 9</p> <p>procedures must include, at a minimum, the following:</p> <p>§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.</p> <p>§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators.</p> <p>§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the _____ and frequency for such development, monitoring, and evaluation.</p> <p>§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.</p> <p>§483.75(d) Program systematic analysis and systemic action.</p> <p>§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success,</p>	F 867		

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F 867	<p>Continued From page 10</p> <p>and track performance to ensure that improvements are realized and sustained.</p> <p>§483.75(d)(2) The facility will develop and implement policies : . (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.</p> <p>§483.75(e) Program activities.</p> <p>§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.</p> <p>§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.</p> <p>§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope</p>	F 867			

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F 867	<p>Continued From page 11</p> <p>and _____ of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.</p> <p>§483.75(g) Quality assessment and assurance.</p> <p>§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:</p> <p>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;</p> <p>(iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, interview and record review, the facility's Quality Assurance and Performance Improvement (QAPI) Program failed to demonstrate that an effective plan of action was implemented to correct identified quality deficiencies in the problem area as evidenced by repeated deficient practices for F759, Free of Medication Errors. The repeated deficient practice involved 10 medication errors identified while observing a total of 31 opportunities, affecting 4 residents, Residents #2, #3, #5, and #6, at the time of the revisit survey.</p>	F 867	<p>(1) What corrective actions will be taken for those residents found to have been affected by the deficient practice:</p> <p>AD Hoc QAPI Meeting was held on _____ with the Administrator, Medical Director, Director of Nursing and interdisciplinary team members. The meeting agenda included the components of Regulations: F759 Free of Medication Error rates 5% or more and F867 QAPI and the areas of concerns communicated</p>		

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F 867	<p>Continued From page 12</p> <p>The finding included:</p> <p>Review of the facility's survey history revealed the facility was cited at F759, Free of Medication Errors, during the recertification survey, with exit date of</p> <p>On at 3:25 PM, an interview was conducted with the Director of Nursing (DON) who was apprised of the medication administration errors. See F759 for details. The DON stated that a plan of correction was completed on for 'Free of Medications Errors' and the last meeting for Quality Assurance and Performance Improvement (QAPI) was held on</p> <p>Review of the facility's plan of correction for the recertification survey with a correction date of was conducted and revealed the Licensed Nursing staff were re-educated on by the Staff Development Nurse / designee on the medication administration process with emphasis on timeliness.</p> <p>Review of the facility's plan of correction included a "Medication Pass Observation" record dated signed by the Consultant Pharmacist for Staff A, Licensed Practical Nurse.</p> <p>Review of the facility's plan of correction included a "Medication Pass Observation" record dated signed by the Consultant Pharmacist for Staff C, Licensed Practical Nurse (LPN).</p> <p>Review of Staff B, Licensed Practical Nurse "Agency Orientation Checklist" signed on documented that the staff completed orientation to the medication and treatment guidelines.</p>	F 867	<p>on survey exit by the Agency for Health Care Administration.</p> <p>(2) How you will identify other residents having the potential to be affected by the same practice and what corrective actions will be taken: The Regional Vice President of Operations re-educated the Administrator on regarding the components of this regulation with emphasis on ensuring quality assurance monitoring of facility processes related Medication Administration.</p> <p>(3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: QAPI meeting was conducted on and by the Administrator. Participation included interdisciplinary team members as well as the Medical Director. Meeting agenda included the components of Regulations: F-759 Free of Medication Error Rates 5 Percent or more F-867 QAPI Education was provided by the Administrator to QAPI team members on related to the elements of the Quality Assurance and Process Improvement program and to ensuring quality assurance monitoring of facility processes related to Medication Administration.</p> <p>(4) How the corrective actions will be monitored to ensure the practice will not</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106005	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/16/2025
NAME OF PROVIDER OR SUPPLIER WEST DELRAY NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 16200 S JOG ROAD DELRAY BEACH, FL 33446		
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F 867	Continued From page 13 The facility failed to have an effective QAPI program that ensured the medication error rate was not greater than 5% (percent).	F 867	recur: The facility Administrator/designee will conduct a quality review of QAPI to ensure quality assurance monitoring of medication administration to ensure ordered medications are being administered in a timely manner and as prescribed by the physician weekly x 4 weeks, and then every 2 weeks x 2 months then PRN as indicated. The findings of this quality monitoring will be reported to the QAPI monthly. Quality Monitoring schedule will be modified based on findings with quarterly monitoring by the Regional Director of Clinical Services / designee		