STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105365	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Altamonte Springs	989 Orienta Ave Altamonte Springs, FL 32701

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36489 Based on interview and record review, the facility failed to provide pharmaceutical services to ensure the acquisition and/or timely administration of physician-ordered medications for 2 of 4 residents reviewed for medication administration, out of a total sample of 8 residents, (#1 and #3). Findings: 1. Review of the medical record revealed resident #1, an [AGE] year-old male, was admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included peptic ulcer disease, difficulty swallowing, and gastrostomy status. Resident #1 was discharged home on 7/16/24. A peptic ulcer is an open sore found on the lining of the stomach or in the first section of the small intestine. These ulcers are often caused by an overproduction of stomach acid and common treatment options focus on medications that reduce the production of stomach acid (retrieved on 7/25/24 from www.hopkinsmedicine.org/health/conditions-and-diseases/peptic-ulcer-disease). A gastrostomy is a surgical procedure in which a tube is inserted directly into the stomach through an incision in the abdomen wall. The gastrostomy tube or G-Tube is used to provide feeding or medications (retrieved on 7/25/24 from www. medical-dictionary.thefreedictionary.com/gastrostomy). Review of resident #1's medical record revealed a care plan for antibiotic use to treat a urinary tract infection and pneumonia initiated on 7/08/24. The interventions included administration of intravenous (IV) antibiotics as ordered. Review of resident #1's Order Summary Report for July 2024 revealed a physician order dated 7/01/24 for Protonix Oral Delayed Release 20 milligrams (mg), Give 1 tablet via G-Tube one time a day for [acid reflux] via G-Tube. The order was discontinued on 7/02/24 and re-started on 7/03/24. A physician order dated 7/07/24 revealed resident #1 was to receive the IV antibiotic Meropenem 500 mg every eight hours for seven days. Protonix is classified as a proton pump inhibitor, a drug that decreases the amount of acid produced in the stomach. The manufacturer's instructions for Protonix Delayed Release tablets read, Swallow whole. Do not chew, break, or crush and indicated patients who had feeding tubes may use Protonix delayed-release granules (retrieved on 7/25/24 from www.drugs.com/protonix.html) (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Meropenem is an antibiotic used to treat severe stomach infections. The manufacturer's instructions read, Skipping doses can increase your risk of infection that is resistant to medication. (Retrieved on 7/25/24 from www.drugs.com/mtm/meropenem.html). Review of an Order Note dated 7/01/24 at 7:13 PM, indicated the physician's order for Protonix triggered a warning for a possible drug-to-drug interaction of moderate severity. The warning was repeated in Order Notes dated 7/02/24 at 12:15 PM and 7/03/24 at 4:32 AM. Review of Progress Notes from 7/01/24 to 7/16/24 revealed no documentation of attempts to contact the pharmacy or the physician regarding possible contraindications for the use of Protonix. The progress notes did not show that nurses identified the drug was ordered in the form of an oral Delayed Release tablet which should not be crushed and administered via a G-Tube. On 7/16/24 at 12:24 PM, in a telephone interview with resident #1's daughter, she expressed concerns regarding her father's medications. She explained he had ulcers, and to her knowledge, he did not receive the medication prescribed for his condition. The resident's daughter said, I don't know what [medications] they were giving. It should be the sprinkles, not extended-release tablets, because he has a G-Tube. She stated she also had concerns regarding timeliness of medication administration, particularly with her father's IV antibiotic. Resident #1's daughter explained the Meropenem doses were scheduled for 6:00 AM, 2:00 PM, and 10:00 PM, but her father sometimes received the medication hours after it was due. She stated she was knowledgeable of the importance of administering antibiotics at the ordered intervals to ensure optimal effectiveness. The resident's daughter recalled on Wednesday 7/10/24, she received a text message from her father at about 6:00 PM, in which he informed her he had not yet received his medication. On 7/16/24 at 1:18 PM, the D Wing Unit Manager (UM) confirmed on the afternoon of 7/10/24, resident #1 informed her he had not received the 6:00 AM dose of Protonix or 2:00 PM IV antibiotic. The UM confirmed medications should be administered within a 2-hour window, one hour before to one hour after the scheduled time. She provided documentation to show the resident's IV Meropenem was delivered on 7/10/24 at 3:42 PM, and recalled her conversation with the resident occurred approximately 30 minutes after the medication was delivered. The UM explained she retrieved the IV medication after speaking to the resident and administered the drug. She acknowledged by the time the medication was completed; it would have been about three hours after the scheduled 2:00 PM time. Review of resident #1's Electronic Medication Administration Record (MAR) Administration Details for IV Meropenem 500 mg revealed resident #1 received three additional doses of the drug outside of the required timeframe. On 7/08/24, he received the 2:00 PM dose at 3:20 PM. He received the dose scheduled for 7/14/24 at 10:00 PM on 7/15/24 at 1:02 AM, and the scheduled 10:00 PM dose for 7/15/24 was administered on 7/16/24 at 12:59 AM. Review of the Medication Administration Audit Report revealed on 7/10/24, resident #1 received his scheduled 2:00 PM dose of Midodrine 2.5 mg at 5:12 PM. The document showed on 7/12/24, he received scheduled 8:00 AM, 8:30 AM, and 9:00 AM morning medications at 10:32 AM. The report revealed on 7/13/24, the resident received his scheduled 8:00 AM, 8:30 AM, and 9:00 AM morning medications between 10:56 AM and 11:30 AM. On 7/16/24 at 2:08 PM, the Director of Nursing (DON) stated she checked the facility's pharmacy portal, and it showed the drug Protonix was never delivered to the facility for resident #1. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the pharmacy's Proof of Delivery form for resident #1 for the period 6/01/24 to 7/16/24 revealed Protonix 20 mg was never shipped to the facility. On 7/17/24 at 9:32 AM, the DON verified it was important to give medications as ordered by the physician to prevent negative outcomes. She acknowledged resident #1 had peptic ulcer disease and the Protonix was necessary to avoid potential complications such as hemorrhaging. The DON validated the resident did not receive the daily dose of Protonix for 15 days. She stated her expectation was nurses would address pharmacy alerts immediately by reaching out to the physician to obtain clarification or a new order. The DON said, They should always follow up; not put it off and wait for somebody else to do it. On 7/17/24 at 11:21 AM, in a telephone interview, Licensed Practical Nurse (LPN) E confirmed she did not call the pharmacy on 7/10/24 when she became aware resident #1's Protonix 20 mg was not available in the facility. LPN E explained she might have retrieved the drug from a bin used to collect other residents' discontinued medications that were to be discarded. On 7/17/24 at 11:38 AM, in a telephone interview, LPN F explained resident #1's dose of Protonix 20 mg was scheduled for 6:00 AM, near the end of her shift. She acknowledged her documentation on 7/11/24 indicated she was awaiting the medication from pharmacy, but she never followed up to ensure the drug was delivered. She LPN F said, I can call pharmacy myself, but by the time I'm finished passing meds, it's time to give report and pass off to the other nurse. She stated she did not have access to the emergency medication dispensing machine and did not ask the supervisor for assistance to acquire the drug. On 7/17/24 at 11:50 AM, in a telephone interview, Registered Nurse (RN) D was informed she signed resident #1's MAR on three days to verify she administered a medication that was never dispensed by the pharmacy for the resident. RN D stated she did not recall any issue related to the resident's Protonix and did not recall attempting to obtain the drug from the emergency dispensing machine. On 7/17/24 at 12:21 PM, in a telephone interview, the facility's Consultant Pharmacist confirmed nurses might receive pharmacy alerts when they entered physician orders. He explained nurses should follow the facility's policies and communicate with providers as necessary. The Consultant Pharmacist confirmed resident #1's Protonix was never dispensed and he verified the drug was not ordered in an appropriate form for G-Tube administration. Review of the facility's policy and procedure for Receipt of Interim/Stat/Emergency Deliveries, dated 1/01/22, revealed nurses should notify the pharmacy immediately if a physician ordered a medication that was not available in the facility's emergency kit. The policy indicated the pharmacy would make an interim or emergency delivery to meet the resident's needs. Review of the facility's educational material for nurses, Medication Administration / Documentation Procedure and Process (undated) revealed nurses should administer all ordered medication and notify the physician if a drug was not given. The document read, If the medication is not available, call pharmacy and get it corrected. 2. Review of the medical record revealed resident #3, an [AGE] year-old male, was admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included paroxysmal atrial fibrillation, heart disease, shortness of breath, depression, and restless leg syndrome. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record revealed resident #3 had a care plan for cardiac risk initiated on 8/08/22, and a care plan for anemia, initiated on 8/10/22. A care plan for mood and behaviors was initiated on 5/05/23. The care plans included interventions that instructed nurses to administer medications as ordered by the physician. Review of resident #3's Medication Administration Audit Report revealed on 7/13/24, he received his scheduled 8:00 AM doses of Simethicone 80 mg, Apixaban 5 mg, Polysaccharide Iron Complex 150 mg, and Florastor at approximately 10:55 AM. The resident received his scheduled 9:00 AM doses of Levaquin 500 mg, Potassium Chloride 20 milliequivalents, Sertraline 50 mg, Mirapex 0.125 mg, and Midodrine HCl 5 mg at approximately 11:00 AM. Review of the facility's policy and procedures for General Dose Preparation and Medication Administration, dated 1/01/22, revealed nurses would verify medication was administered at the correct time and within specified timeframes.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36489 Based on interview and record review, the facility failed to ensure the medical record accurately represented medication administered for 1 of 4 residents reviewed for medication administration, out of a total sample of 8 residents, (#1). Findings: Review of the medical record revealed resident #1, an [AGE] year-old male, was admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included peptic ulcer disease, difficulty swallowing, and gastrostomy status. Review of resident #1's Order Summary Report for July 2024 revealed a physician order dated 7/01/24 for Protonix Oral Delayed Release 20 milligrams (mg) once daily for acid reflux. Review of the pharmacy's Proof of Delivery form for resident #1 for the period 6/01/24 to 7/16/24 revealed Protonix 20 mg was never shipped to the facility. Review of the resident #1's Medication Administration Record (MAR) for July 2024 revealed the physician order for Protonix Oral Delayed Release 20 mg was transcribed to the document and scheduled for daily administration at 6:00 AM. The document was initialed by six nurses over the 15-day period from 7/02/24, when the medication should have been started, until 7/16/24. The MAR showed resident #1's Protonix 20 mg was not initiated on the morning of 7/02/24, instead the physician order was discontinued at 2:33 AM, with no associated documentation in the medical record to explain why the drug was not started or to show the physician was notified. Daily documentation on the MAR and Progress Notes revealed the following: On 7/03/24 at 4:31 AM, Registered Nurse (RN) A re-entered the order for Protonix 20 mg and received a drug interaction warning. There was no documentation to reflect RN A contacted the physician or the pharmacy regarding the alert. On 7/04/24, Licensed Practical Nurse (LPN) B initialed the MAR to verify she administered the drug for resident #1. On 7/05/24, RN C initialed the MAR to indicate she administered the resident's 6:00 AM dose of Protonix 20 mg. On 7/06/24 and 7/07/24, the MAR showed RN D's initials as verification she gave resident #1 Protonix 20 mg on both days. On 7/08/24, LPN B signed the document to confirm she administered the scheduled drug at 6:00 AM. On 7/09/24, RN C's initials indicated she administered resident #1's Protonix 20 mg at 6:00 AM. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/10/24, LPN E noted she did not administer resident #1's scheduled Protonix 20 mg due to awaiting pharmacy delivery. There was no associated progress note to show LPN E notified the physician the drug was not available. On 7/11/24, LPN F initialed the MAR to verify she administered the scheduled drug at 6:00 AM. On 7/12/24, LPN F noted she did not administer resident #1's Protonix 20 mg and was awaiting pharmacy. The medical record did not show the physician was notified. On 7/13/24, RN D initialed the MAR to validate she administered the drug. On 7/14/24, LPN E's documentation on the MAR showed she gave resident #1 his Protonix 20 mg at 6:00 AM. On 7/15/24, the MAR was blank, with no initials or attached progress note related to administration of the resident's Protonix 20 mg. On 7/16/24, LPN E initialed the MAR to verify she administered the scheduled 6:00 AM dose of Protonix 20 mg. On 7/16/24 at 2:08 PM, the Director of Nursing (DON) explained when she contacted the pharmacy and reviewed the pharmacy portal, she discovered resident #1's Protonix 20 mg was never delivered. When informed the MAR showed nurses' initials to indicate the drug was administered as ordered, she stated they were probably retrieving the medication from the facility's emergency medication dispensing machine located on the D Wing. On 7/16/24 at 3:22 PM, the DON stated she contacted the pharmacy regarding a report of drugs removed for resident #1 from the emergency medication dispensing machine. The DON explained the report showed nurses did not retrieve Protonix 20 mg for the resident from the machine. On 7/17/24 at 9:32 AM, the DON stated she interviewed five of the six nurses who were assigned to resident #1 during the time he had the physician's order for Protonix 20 mg. She said, Nobody could give a good answer. She acknowledged the nurses documented a task that was not completed, and stated that was not her expectation of licensed personnel. The DON said, The medical record must be accurate to reflect the care we provide to the patients. On 7/17/24 at 11:21 AM, in a telephone interview, LPN E acknowledged she initialed the MAR on 7/14/24 and 7/16/24 to indicate she administered resident #1's Protonix 20 mg. LPN E verified the DON informed her the medication was never delivered to the facility. She stated she might have used medications prescribed for another resident. On 7/17/24 at 11:38 AM, in a telephone interview, LPN F stated she could have mistakenly signed off that she administered resident #1's Protonix 20 mg on 7/11/24. On 7/17/24 at 11:50 AM, in a telephone interview, RN D was informed she signed resident #1's MAR on three days to verify she administered a medication never dispensed by the pharmacy. RN D stated she did not recall any issue related to the resident's Protonix 20 mg. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's policy and procedure for Medical Record Organization, issued on 3/21/24, read, All medical records must be complete, accurately documented, readily accessible, and systematically organized. The document indicated residents' medical records should contain accurate information that supported diagnoses and treatments, documented progress, and promoted continuity of care between providers.