STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106138	A. BUILDING _____ B. WING _____	**08/27/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OAKBRIDGE HEALTHCARE CENTER	**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)
F 0755 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**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** Based on record reviews and interviews, the facility failed to ensure the accurate acquiring and administering of all drugs and biologicals to meet the needs of one (#1) out of three sampled residents following admission to the facility. Findings included: Resident #1 was admitted on [DATE] from another Long-term care facility. The Admission Record included [DIAGNOSES REDACTED]. The review of Resident #1's electronic clinical record, on 8/27/20 at 11:30 a.m., revealed the Admission/Readmission Data Collection form, dated 8/26/20 at 16:46 (4:46 p.m.) was not completed. A progress note, dated 8/27/20 at 9:26 a.m., identified Resident #1 was admitted yesterday evening and due to issues with Wi-Fi his orders were not able to be entered into Point Click Care (PCC). Orders transcribed this am and call placed to pharmacy to ensure delivery. Advanced Registered Nurse Practitioner (ARNP) aware of delay in medication orders. The review of the progress notes did not identify a note dated 8/26/20 to indicate that the physician or ARNP was notified of the delay in medications on 8/26/20. The Medication Reconciliation form, dated 8/26/20 at 16:46 (4:46 p.m.), did not indicate medications were reconciled with the physician. Photographic evidence was obtained at 11:37 a.m. on 8/27/20. The progress notes or Admission/Readmission Data Collection for Resident #1 did not indicate staff had confirmed with the transferring facility that the resident had received evening medications prior to transfer. A review of the Physician Orders that the facility received from the previous facility indicated the following physician orders: - [MEDICATION NAME] 100 milligrams (mg) - Give 200 mg twice daily for [MEDICAL CONDITION]; - [MEDICATION NAME] 50 mg daily related to Diabetes Mellitus; - [MEDICATION NAME] 1000 mg twice daily for Diabetes Mellitus; - [MEDICATION NAME] 64.8 mg daily for [MEDICAL CONDITION]; - [MEDICATION NAME] and [MEDICATION NAME] ([MEDICATION NAME]) level every night shift starting on the 27th and the 28th of every month, dated 10/27/19. A review of this facility's Medication Administration Record (MAR) for Resident #1 identified the following: - [MEDICATION NAME] 64.8 mg - Give 1 tablet by mouth one time a day related to Other [MEDICAL CONDITION] not intractable without [DIAGNOSES REDACTED], start date 8/28/20 at 7:00 a.m.; - [MEDICATION NAME] Capsule 100 mg ([MEDICATION NAME] Sodium Extended) - Give 2 capsules by mouth two times a day related to Other [MEDICAL CONDITION] not intractable without [DIAGNOSES REDACTED], Start date 8/27/20 at 1500 (3:00 p.m.); - [MEDICATION NAME] (HCl) Tablet 1000 mg - Give 1 tablet by mouth two times a day related to Type 2 Diabetes Mellitus without complications, start date 8/27/20 at 1500 (3:00 p.m.). The review indicated Resident #1 was not administered nor scheduled to receive the following: - Daily dose of [MEDICATION NAME] on 8/27/20; - Morning dose of [MEDICATION NAME] on 8/27/20; - Morning dose of [MEDICATION NAME] HCl on 8/27/20. A review of Resident #1's physician orders did not include the previous facility's order for a [MEDICATION NAME] and [MEDICATION NAME] level to be drawn on 8/27/20. A review of the resident's MAR indicated Resident #1's prescribed medication, scheduled for the morning dose, was not to start until 8/28/20, which would indicate the resident was not to receive those medications on 8/27/20, the day after his admission. At telephone interview was conducted, at 1:04 p.m., with Staff Member A, Registered Nurse. She confirmed that Resident #1 arrived at 5:00 p.m. to the facility and that she was the one assigned to the resident. Staff A stated the Wi-Fi was working during her shift on 8/26/20. When asked why the physician orders for Resident #1 was not input into the computer until the morning of 8/27/20, she stated she had two (2) admissions yesterday. The staff member stated she had passed in report to the 7 p.m. - 7 a.m. nurses that she was unable to put the orders into the computer. Staff A stated she did not believe the resident had received any medication last night (8/26/20). The Nursing Home Administrator stated, at 2:00 p.m., on 8/27/20, that the Internet Contractor had been having issues since 1:30 a.m., on 8/26/20. An interview was conducted, on 8/27/20 at 2:47 p.m., with the Director of Nursing and the Assistant Director of Nursing (ADON). The DON stated the MDS nurse had noticed this morning that nothing had been done with Resident #1's admission. The ADON and DON confirmed Resident #1's [MEDICATION NAME] and [MEDICATION NAME] were not given on 8/26 or the morning of 8/27/20. The review of the Admission/Readmission Data Collection confirmed that there was indication that the physician reconciled the medications. The DON stated staff should have asked the physician if the daily medications could be given when they arrived from the pharmacy. He stated staff should have noted that the physician was notified of the medication orders and the conversation should have been documented. The DON stated his expectation, if the Internet was down, that staff should have written telephone orders and MAR and that they had been faxed to the pharmacy last night. When asked if nurses had a type of checklist or procedure to follow during an admission, the DON and ADON stated no, but would put one together. The ADON stated the laboratory draw for Resident #1's [MEDICATION NAME] and [MEDICATION NAME] would have been found when they scrubbed the chart, which was not completed as staff was busy getting you stuff. At 3:36 p.m, an interview was conducted with the Consultant Pharmacist. The Pharmacist stated her expectation would have been if staff was unable to enter orders into the computer that the medications be given per physician orders from the Emergency Drug Kit (EDK) and that the medications be requested by fax and that staff start administering medications with a paper MAR. She stated [MEDICATION NAME] does have a long half life and the level of medication would not drop drastically and if [MEDICATION NAME] was ordered this morning, her assumption would have been that the dose of [MEDICATION NAME] would have been given today when the medication was delivered or from the EDK, after speaking with the physician. When asked for a policy regarding Admissions, the Nurse Consultant provided a policy titled, Admission Assessment, effective 11/20/2014 and revised on 8/22/2017. The policy stated, in its entirety, At the time of admission or readmission, the Nurse shall initiate the Data Collection Form. Pertinent information shall be collected by physical review, interview with resident and family and review of the resident's available medical records. The Data Collection Form will be completed within 24 hours. Initiate care plan. When asked if there was a procedure that nurses were to follow for the admission process, she stated, no.

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

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.