STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105261	A. BUILDING _____ B. WING _____	**05/28/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
UNIVERSITY WEST REHABILITATION CENTER	**545 WEST EUCLID AVENUE DELAND, FL 32720**

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 observation, clinical record review, staff interviews and facility policy and procedure review, the facility failed to ensure appropriate administration of medication for two (Resident #5 and Resident #6) of three residents observed during medication administration. The findings include: On 05/27/2020 at 10:15 AM, Employee A, Registered Nurse (RN), was observed with two small medication cups, each with a different resident name written in black marker (Resident #5 and Resident #6). During observation of Employee A, she confirmed that there were two resident medications poured at the same time. Each of the two medication cups were given to the two residents on 05/27/2020 at 10:19 AM. Employee A confirmed that she provided the medications to Resident #5 and Resident #6 and then documented administration afterwards. On 05/28/2020 at 8:30 AM, Employee A confirmed that she documented the administration of the following 8:00 AM medications to Resident #5 on 05/27/2020: [MEDICATION NAME] 100 mg (milligrams), [MEDICATION NAME] 5 mg, Aspirin 81 mg, D3-1000 unit, Iron tablet 325 mg, Vitamin C 500 mg, Calcium [MEDICATION NAME] 500 mg, [MEDICATION NAME] 500 mg, [MEDICATION NAME] 100 mg, [MEDICATION NAME] 750 mg and Klonopin 1 mg. Employee A confirmed that these were the medications in the cup marked with Resident #5's name. On 05/28/2020 at 8:30 AM, Employee A confirmed that she documented the administration of the following 8:00 AM medications to Resident #6 on 05/27/2020: Aspirin 81 mg, [MEDICATION NAME] 500 mg, [MEDICATION NAME] 50 mg and Potassium Chloride 20 mEq (milliequivalents). Employee A confirmed that these were the medications in the cup marked with Resident #6's name. Employee A also confirmed that she was not to have pulled two separate residents' medications at the same time. An interview was conducted with the Director of Nursing (DON) on 05/28/2020 at 8:54 AM. The DON confirmed that Employee A should not have two resident medications pulled at the same time. The DON stated she would conduct 100% training for staff on safe medication administration practices with adherance to the facility's policies and procedures. A review of the facility's pharmacy policy revealed the following on page 87 under letter B for Administration at line 4: When medications are administered by mobile cart .medications are administered at the time they are prepared. Medications are not pre-poured either in advance of the med pass or for more than one resident at a time. .
F 0919 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that a working call system is available in each resident's bathroom and bathing area.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the use of mechanically activated call bells during call system repairs for four (Residents #1, #2, #3 and #4) of 47 residents who were sampled for call bell access from a total census of 47 residents. The findings include: During the initial tour of the facility on 05/27/2020 at 10:13 AM, an observation was made of red flashing call lights over the doorways of rooms 103 (two residents), 107 (two residents) and 111 (three residents). The call lights were inoperable. On 05/27/2020 at 10:13 AM, Employee B, Licesned Practical Nurse (LPN), was interviewed and confirmed that the call lights were broken and the residents were issued hand held bells. Employee B, LPN, confirmed that Resident #3 was just moved to room [ROOM NUMBER], bed D. On 05/27/2020 at 1:31 PM, an observation of Resident #1 was made after noticing a blinking red light above the door to Resident #1's room. When Resident #1 was interviewed at the time of this observation, the resident replied that the call light had been inoperable for several weeks, then stated about four to six weeks. During the room observation, there was no call bell observed for Resident #2's bed (bed B). A tour of the facility's 100-numbered unit was conducted on 5/28/20 at 11:50 AM,. The call lights were observed flashing red over the door for rooms 111 (3 residents) and 107 (2 residents). The residents in rooms 111 D and 214 B did not have a mechanical call bell provided to them while the call light system was inoperable on 05/27/20 and 05/28/20. An interview was conducted with Resident #4 who was admitted to room [ROOM NUMBER] Bed B on 5/28/20 at 12:00 PM. He stated that the call light had been broken since he was admitted in March 2020 and he added, The bell provided is ineffective. He further stated that he required assistance with incontinence and his roommate kept the door closed all the time. When he rang for help with the mechanical bell, the staff could not hear it, and it took a long time for the staff to come and assist him. On 05/28/2020 at 8:20 AM, an observation of Resident #2 revealed she was seated at the side of her bed. She stated she needed her lunch box packed before she went to her [MEDICAL TREATMENT] appointment. The lunch box was empty. She reported that she was new to the room. The call light indicator above the door to room [ROOM NUMBER] was flashing red. Bed A (Resident #1) already confirmed that the call light did not work. An interview was conducted with Resident #1 in room [ROOM NUMBER], bed A on 05/28/2020 at 11:42 AM. She stated she had the call bell, but yesterday afternoon after shift change, she stated she needed to go to the bathroom and pressed the bell for help. No one came. She stated if staff could tell where the bell sound was coming from, it would help, but no one came and the resident soiled herself. She stated the nurse aide did eventually come and clean her up, but she could have made it to the bathroom without becoming incontinent if she had received help to transfer. An interview was conducted with Resident #3 on 5/28/20 at 12:10 PM. She stated she did not have a temporary call bell. When asked if she would like a bell, she replied yes since she had been shouting for the staff thus far when she needed help. Resident #3 was admitted to room [ROOM NUMBER]m bed D. An interview was conducted with Employee C, Certified Nursing Assistant (CNA), on 05/28/2020 at 12:00 PM, when the resident rooms were being checked for functioning call systems. She confirmed that call bells should have been in rooms 214, bed B and stated, (Resident #2) just moved to that room. Employee C further stated she thought the call bells in rooms [ROOM NUMBERS] had been inoperable for about a month. An interview was conducted with Resident #2 on 05/28/2020 at 12:25 PM. The call light was flashing over the doorway to her room (214, bed B). She confirmed she had not had a manual call bell since she moved to room [ROOM NUMBER] from room [ROOM NUMBER]. She confirmed she could not use the call light to get help because the system had not worked for a while. She did say that while she was in room [ROOM NUMBER] she did have a call bell and was able to call for help without shouting out. She said that she did not think about requesting a call bell because she just got to this new room. She thought that staff would take care of it. An interview was conducted with the Director of Maintenance on 05/28/2020 at 12:57 PM. He confirmed he was aware of the call light system having been inoperable since February 2020 because parts were not available to repair the system. He confirmed that various problems had been encountered while trying to fix/repair the call system. He also confirmed that the call system for Residents #1, #2, #3 and #4 was inoperable, and the facility had not provided an effective call bell for Resident #1 that satisfied her needs on 05/27/2020 when she had to use the bathroom. The facility had not provided a call bell for Resident #4 that could be heard when the door to the room was kept shut by the roommate, and the facility had not provided call bells for Residents #2 and #3, resulting in their need to shout for assistance or ask other residents who shared the room to call out for assistance.

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.

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F 0919 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) There were no portable call bells for Residents #2 and #3. The Director of Maintenance confirmed that there was no documented evidence verifying that the call system or manual call bell system ensured Resident #1's, #2's, #3's or #4's needs were met. The Director of Nursing (DON) was interviewed on 05/28/2020 at 1:30 PM. She confirmed that the call lights from the wall had not been operational for about six weeks for room [ROOM NUMBER] A, B and C or room [ROOM NUMBER] A, B and C. This impacted Residents #1 and #2 (214, beds A and B). On 05/28/2020 at 1:49 PM, an interview was conducted with the Administrator, the DON and the Director of Maintenance. Each acknowledged the concerns related to the facility's call system. None could present any documentation supporting an audit procedure related to ensuring the call system being repaired was operable and met the needs of Residents #1, #2, #3 and #4. A list was provided entitled Rooms need light fixed over bed/call light, which revealed that the facility documented room [ROOM NUMBER]-both lights worked (Resident #4 resided in room [ROOM NUMBER]-B and the call light was inoperable), room [ROOM NUMBER]-A bed light needed a pull string, C-bed light did not work (Resident #3 resided in room [ROOM NUMBER]-D and the call light was inoperable) and 214-C bed light did not work (Resident #2 resided in room [ROOM NUMBER]-B and Resident #1 Resided in 214-A and was provided a push call bell because Bed A, B and C call bell was inoperable on 05/27/20 and 05/28/20). The rooms confirmed by observation and interview were not documented with inoperable call systems based on this review. A review of the medical record for Resident #1 was conducted. The most recent admission was on 03/09/2020 with [DIAGNOSES REDACTED]. Resident #1's brief interview for mental status (BIMS) score was 14 out of 15 which indicated the resident was cognitively intact. The care plan for Resident #1 documented for activities, Resident #1 does require assistance getting out of bed, capable of independently choosing and attending activities when able. Resident has [MEDICAL CONDITION] and is at risk for fractures and resident is frequently incontinent of bowel and bladder. She does ask for the bedpan for her bowels occasionally, but cannot always hold it. A review of the medical record for Resident #2 was conducted. Resident #2 was readmitted on [DATE] with multiple comorbidities including major [MEDICAL CONDITIONS], and [MEDICAL CONDITION]. A BIMS score documented at 15 out of a possible 15 points indicated that Resident #2 was cognitively intact. The care plan included [MEDICAL CONDITION] drug use, activities of daily living self-care deficit evidenced by weakness and Resident #2 was at risk for falls with a documented intervention that included, provide environmental adaptations, call light within reach. Resident #2 was also care planned for [MEDICAL TREATMENT]. A review of the medical record for Resident #3 was conducted. Resident #3 was readmitted on [DATE] with multiple comorbidities which included juvenile arthritis, [MEDICAL CONDITION] disorder, right hand contracture, [MEDICAL CONDITION] right lower limb, age-related [MEDICAL CONDITION] and difficulty in walking. Resident #3 had a documented BIMS score of 10 out of 15, indicating some cognitive limitations. The care plan was reviewed for Resident #3 and documented a risk for falls. The goal was to minimize falls. The intervention included adaptive devices call light within reach. Resident #3's care plan included [MEDICAL CONDITION] and at risk for fractures. A review of the medical record for Resident #4 was conducted and documented that Resident #4 was admitted on [DATE]. The resident's [DIAGNOSES REDACTED]. Resident #4 had a BIMS score of 14 out of 15, indicating that he was cognitively intact. The care plan for Resident #4 was reviewed and documented he had an ADL self-care deficit. .