STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105965	A. BUILDING _____ B. WING _____	**07/08/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MANORCARE HEALTH SERVICES	**1450 EAST VENICE AVENUE VENICE, FL 34292**

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 0552 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that residents are fully informed and understand their health status, care and treatments.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and resident family interview and record review, the facility failed to ensure they informed the resident and/or their legal representative of the risks and benefits of proposed treatment for 1 (Resident #1) of 3 resident medication regimen's reviewed. The facility's failure to provide the resident and/or their legal representative of the risks and benefits of proposed treatment and treatment alternatives to ensure the resident was not adversely affected to maintain their mental and/or physical well-being. The findings included: On 7/8/20 review of Resident #1's medical record revealed the pain management physician ordered [MEDICATION NAME] 5 micrograms (mcg) patch (a narcotic [MEDICATION NAME]) for chronic pain on 1/26/20. The pain management physician wrote in his 1/26/20 progress note, Resident #1 reported her low back pain was not controlled. He discussed pain control options and elected to try [MEDICATION NAME] 5 mcg patch. On 3/10/20 the pain management physician wrote in his progress note the daughter had requested re-evaluation of pain options. He writes Resident #1 had not had any noted side effect with the [MEDICATION NAME] 5.0 mcg dose and is electing trial of [MEDICATION NAME] 7.5 mcg patch. Review of Resident #1's medical record revealed her daughter was listed as Resident #1's Durable Power of Attorney (DPOA) and Health Care Surrogate (HCS). Further review of the medical records revealed documentation Resident #1's daughter was not informed of the risk and benefits for the use of [MEDICATION NAME] 5 mcg on 1/26/20 and the increase to 7.5 mcg on 3/10/20. On 7/8/20 at 12:30 p.m., in an interview with Resident #1's Nurse Practitioner (NP) and Primary Care physician, they said Resident #1 was under a pain management physician to address her chronic pain. While they review all their patients' medication, if another physician orders [REDACTED]. The NP said on 6/4/20 she called Resident #1's daughter since she was her DPOA/HCS about Resident #1's failure to thrive and discuss the possible options. She said during the call she went over Resident #1's current medication regimen and the daughter told her she was not aware Resident #1 was receiving a [MEDICATION NAME] 7.5 mcg patch for pain. The NP and Primary Care physician said they were unaware Resident #1's daughter was not explained the risk and benefits for the [MEDICATION NAME] and the alternatives prior to the pain management physician order [REDACTED]. On 7/8/20 at 3:30 p.m., interview Resident #1's daughter said she is Resident #1's DPOA and HCS. She said she knew her mother was being seen by pain management, but she was not informed her mother was on a [MEDICATION NAME] for her chronic pain. The daughter said she did not know her mother was on the [MEDICATION NAME] until 6/4/20 when the NP called her about her mother's decline in health. On 7/8/20 at 4:30 p.m., in an interview with the Administrator and Director of Nursing, they said after a review of Resident #1's medical record they were unable to find documentation Resident #1's DPOA/HCS was informed of the pain management physician order [REDACTED]./10/20. They confirmed there was no documentation Resident #1's daughter was informed of the risks and benefits for the use of the [MEDICATION NAME] and treatment alternatives.

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.