STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105238	A. BUILDING _____ B. WING _____	**07/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HERITAGE PARK REHABILITATION AND HEALTHCARE	**2826 CLEVELAND AVE FORT MYERS, FL 33901**

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 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and resident and staff interview the facility failed to immediately inform the physician of a physical assault resulting in injury for 1 (Resident #611) of 2 residents reviewed. The findings included: Review of the Nursing Home Federal Reporting Five-day report revealed on 6/23/20 at 3:30 p.m., the Executive Director reported Resident #610 was found in Resident #611's room with Resident #611's hand in his mouth. Resident #611 verbalized that man came in and sat on my bed. When I tried to get him to leave, he bit my hand. The Executive Director, who was a Licensed Practical Nurse (LPN), conducted a head to toe skin sweep and observed a skin tear to Resident #611's right hand. The facility's immediate response included MD (physician) Notified for both (name Resident #611) and (name Resident #610). Review of the nurses notes and physician progress notes [REDACTED].#611's physician was notified of the incident. On 7/14/20 at 9:00 a.m., during an interview Unit Manager LPN Staff D said she did not complete an incident report or notify the physician. On 7/14/20 at 9:37 a.m., during an interview, LPN Staff E said she did not write an incident report. She said the clinical record did not have documentation Resident #611's physician was notified of the physical altercation between the two residents resulting in the skin tear to Resident #611's right hand. LPN Staff E said Resident #611's physicians preferred method of communication was via text messages. LPN Staff E took a cellular device from her pocket and scrolled through messages. She said she could not find documentation she notified the physician. On 7/14/20 at 9:55 a.m., during an interview Resident #611 said Resident #610 came out of nowhere, assaulted him, and bit his right hand. Resident #611 said the doctor never looked at his hand. The nurse put some [MEDICATION NAME] (antibiotic) on it but that was it. He said his hand was still bothering him and was stiff. On 7/14/20 at 10:40 a.m., during a telephone interview with Resident #611's attending physician, he said he was not aware of any incident involving Resident #611. He said no one told him about another resident biting him. He said he would come to the facility on [DATE] and take care of it.
F 0600 **Level of harm -** Actual harm **Residents Affected -** Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of the facility's abuse and neglect policy, residents and staff interviews, the facility failed to investigate allegations of abuse. The facility failed to implement adequate supervision and provide the necessary care and services for 1 (resident #610) of 1 resident with documented violent behavior in multiple incidents of resident-to-resident physical abuse toward 3 (Resident #80, #611 and #612) of 3 vulnerable residents reviewed. The findings included: The facility policy N-1265, Abuse, Neglect, Exploitation and Misappropriation (revised 11/28/17) specified, It is inherent in the nature and dignity of each resident at the center that he/she be afforded basic human rights, including the right to be free from abuse, neglect, mistreatment and exploitation .abuse is the willful infliction of injury, intimidation with resulting physical harm or mental anguish. All reported events (bruises, skin tears, falls, inappropriate or abusive behaviors) will be investigated by the Director of Clinical Services. The Abuse Coordinator or his/her designee shall investigate all reports or allegations of abuse, neglect, misappropriation and exploitation. Review of the clinical record revealed Resident #610 was admitted to the facility on [DATE]. The history and physical dated 6/11/20 indicated Resident #610 was transferred from a local hospital where he was admitted because of increased agitation. He had become combative and required a sitter for safety. Resident #610's [DIAGNOSES REDACTED]. The individualized care plan dated 6/15/20 indicated Resident #610 has a potential to be physically aggressive, combative during cares related to dementia and [MEDICAL CONDITION]. The documented goal was The resident will not harm self or others through the review date. The interventions included Administer medications as ordered. Monitor/document for side effects and effectiveness. Psychiatric/Psychogeriatric consult as indicated. The medication regimen included: [MEDICATION NAME] sprinkle (a drug used as a mood stabilizer) 125 milligrams 8 capsules daily with dinner for [MEDICAL CONDITION] and 2 capsules daily at 9:00 a.m., for behaviors. On 6/11/20 the Advanced Practice Registered Nurse (APRN), assessed Resident #610 for agitation, aggression, anxiety, depression and psychiatric medication management. The APRN documented the quality of symptoms were mild, moderate. He documented Resident #610 experienced anxiety, restlessness, pacing/psychomotor activation, emotional lability, poor impulse control, aggressive behaviors. The APRN documented Nursing staff was advised to contact provider with onset of any adverse reactions or worsening in patient mood after dosing of medication. Review of Resident #610's Medication Administration Record [REDACTED]. The clinical record lacked documentation of the reason why the medication was not administered as ordered. On 6/12/20 at 1:40 p.m., the nurse documented in the progress notes Pt (patient) had incident this afternoon. Pt was found in room feeding his roommate. Plate was taken from this resident, he got aggressive against Certified Nursing Assistant (name) and the CNAs took him back to his chair at which time he got up and then punched the CNA (name) in the face, breaking her lip. MD (physician) and family notified and report completed. Will continue to monitor patient for any changes in behavior. Resident #610 was care planned for behaviors and listed strategies staff were to use to manage the residents behaviors. On 6/13/20 the licensed nurse documented in the nurses progress notes at 3:00 a.m., Resident #610 continues to wander around the unit, reaching over nursing station and trying to grab the nurse's face. When the aides attempted to redirect him, he became agitated and threatened the staff with physical aggression. On 6/13/20 the physician documented in a progress note nursing reports px (patient) became agitated and physically combative and hit a CNA last night; px unable to answer questions appropriately; he wanders around into other residents' rooms. On 6/13/20 the physician added [MEDICATION NAME] (antipsychotic) 2.5 milligrams twice a day to the medication regimen. The MAR indicated [REDACTED]. On 6/17/20 the physician documented in a progress note Px (patient) seen and examined; he remains confused/demented and nursing reports px still exhibiting combative behavior/agitation, going into other residents' rooms and sitting on other residents; as per therapists he continues to hallucinate; seen in front of mirror arguing with himself .talking about snakes around him. On 6/17/20 the physician increased the [MEDICATION NAME] to 5 milligrams by mouth twice a day. On 6/19/20 Resident #610 refused to take the medications. On 6/23/20 at 1:10 p.m., the Licensed Practical Nurse documented in the nurses progress notes Resident was noted to be combative with staff and other residents. Resident has been pacing up and down the hallway yelling at people and grabbing objects off the med (medication) cart and nursing station. CNA attempted to redirect resident to his room and resident swung at CNA and hit her in the chin. Dr. (name) was notified of resident's behavior and gave verbal order for 1 X dose (1time dose) of IM (intramuscular) [MEDICATION NAME] (used to treat symptoms of acute [MEDICAL CONDITION]) r/t (related to) severe agitation. IM [MEDICATION NAME] was administered to resident at 1347 (1:47 p.m.). The clinical record did not contain documentation Resident #610 was monitored

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 0600 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) for the effectiveness of the [MEDICATION NAME]. The next entry in the nurses notes dated 6/23/20 at 4:00 p.m., indicated Resident was found in another resident's room on top of him biting him. MD was notified and gave verbal order to sent to the ER (emergency room) for eval (evaluation) and tx (treatment). On 7/13/20 at 12:15 p.m., the Director of Nursing (DON) said in his mind and based on his judgement the incident was not abuse since the resident (Resident #610) is confused. On 7/14/20 at 9:00 a.m., during a telephone interview Licensed Practical Nurse (LPN) Staff D identified herself as the unit manager. She said Resident #610 was mostly in the hallway pacing up and down but and would go into other residents' rooms. On 6/23/20 at 1:30 p.m., he became very aggressive with a CNA and hit her. LPN Staff D said she notified the physician who ordered a shot of [MEDICATION NAME]. She said she spoke to the ED (executive director) about placing the resident on one-on-one supervision, but they never did. She said the next thing she remembers was LPN Staff E yelling for her to come in a room. When she got to the room Resident #610 was on top of Resident #611 and was biting his right hand. She said it took both her and LPN Staff E to get Resident #610 off Resident #611. She contacted the physician who ordered to send Resident #610 to the hospital. She said she didn't know what they did for him at the hospital, but they sent him right back without any orders. LPN Staff D said they probably snowed him because he was very sleepy. LPN staff D said once Resident #610 tried to strangle her. He walked up behind her and placed his forearm and biceps around her throat. She said when she tried to remove his arm, he squeezed a little bit tighter. She said she had to wave at the nurse at the nurse's station to come to her help and they were able to loosen the grip around her throat. LPN Staff D said she reported all those incidents to the ED and again requested Resident #610 to be placed on one-on-one supervision but they never did. On 7/14/20 at 9:37 a.m., LPN Staff E said Resident #610 was very verbally and physically abusive toward females. She said he could be abusive towards males too. She said on 6/23/20 after LPN Staff D injected Resident #610 there was no increased supervision put in place to monitor the resident. She said she just remembered Resident #611 yelling. When she looked in the room it seemed like Resident #610 was trying to mess with his (Resident #611's) PEG (gastric) tube. She said Resident #611 had marks on his hand and said Resident #610 bit him. LPN Staff E said she did not write an incident report but monitored the mark on the resident's hand. She said the skin was broken and had a mark that looked like it was made by 2 front teeth. On 6/23/20 at 8:34 p.m., the nurse documented in the nurses notes Resident #610 returned from the emergency room and was resting quietly. She documented they initiated every 15 minutes check on the resident. On 7/14/20 at 9:35 a.m., during an interview CNA Staff J said Resident #610 was agitated. He went after a couple of her coworker. They had to redirect him constantly. He would try to get out of the door a lot. He wandered into other residents' rooms. They tried to keep him in the dining room and entertain him. He would go and sit on his roommate's legs quite a bit while the roommate was in bed. She said when they tried to redirect him that's when he would get agitated and violent. She said she never understood why he kept going to the roommate's bed and sit on his legs. She said she reported it to the nurse and also reported it to the Administrator. She said, to be honest with you, nothing changed, nothing happened. She said she is was aware of 2 incidents when he punched CNA Staff I in the face. On 7/14/20 at 9:55 a.m., during an interview with Resident #611, he said Resident #610 came out of nowhere and assaulted him. He said he bit his right hand. Resident #611 said the doctor never looked at his hand. The nurse put some [MEDICATION NAME] on it but that was it. He said his hand is still bothering him and is stiff. On 7/14/20 at 12:25 p.m., CNA Staff I said Resident #610 was very hard to deal with. She said he hit her several times during his stay here. She reported it to the Administrator who said Resident #610 had the right to walk as he pleased and nothing was done. On 7/14/20 at 4:10 p.m., CNA Staff H said Resident #610 was very aggressive and would fight when they provide care. She said the nurse was aware. Once he grabbed a nurse by the neck. He also would wander in other residents' rooms. She said they told the Administrator it was impossible to watch him all the time as they had other things to do. They reported that to the nurse. She said sometimes they would tell the CNAs to make rounds on him (Resident #610) every 15 minutes to 30 minutes. CNA Staff H said there was no way they could watch him all the time. On 7/14/20 at 4:34 p.m., during a telephone interview Certified Nursing Assistant CNA Staff G said Resident #80 was always complaining about Resident #610. CNA Staff G said Resident #80 complained Resident #610 was always getting into his bed and pulling his pillow. She said Resident #610 was very strong and aggressive. He would go into females' rooms and they were afraid of him. She said many times they would put the call light on, and she had to go and try to remove Resident #610 from other residents' rooms. She said Resident #610 should have been on one-on-one supervision or placed on a specialized unit as it was impossible to keep an eye on him when staff are in the rooms taking care of other residents. She said they finally sent him to the hospital but it was too late as he had already hurt other residents. Review of the 24-hour report/change of condition report revealed the following: On 6/23/20 Resident #610 was exhibiting behaviors and going into other rooms and other residents were becoming upset. On 6/26/20 Registered Nurse (RN) Staff F documented on the 24-hour report form Resident #610 slept in a different room as the roommate threatened to educate Resident #610 on his bad behavior. The nurse documented Resident #80 said Resident #610 tried to get in bed with him, said he tried to put a pillow over his face. RN staff F documented she was skeptical but requested to move Resident #610 to a different room. On 7/15/20 at 10:00 a.m., during an interview the Director of Nursing (DON) reviewed the 24-hour report/change of condition log and said he did not investigate the incident when Resident #80 reported Resident #610 tried to put a pillow over his face. He said he was not aware Resident #610 had become aggressive with other residents and did not investigate. After reviewing the clinical record, the DON said he could not locate any documentation of increased monitoring or interventions to prevent Resident #610 from going into other residents' rooms and attacking them. He said there was no policy, process or formal documentation required when a resident is placed on 15-minute checks. He said he did not have any documentation the facility investigated any incident where Resident #610 assaulted other residents. On 7/13/20 at 5:50 p.m., the RN MDS Coordinator said she was responsible to update the care plan with appropriate interventions for Resident #610. She said she gets her information by going through the chart and usually speaks to the nurse. She said the clinical team discusses behaviors and [MEDICAL CONDITION] medications every day. If there is an incident involving a resident, she would revise the care plan. After looking at Resident #610's care plan she said physical aggressive behavior would be a reason to update the care plan with new interventions but, it doesn't look like I revised this one. She said staff was to redirect, but she does not see anything specific to address the behavior of the resident. On 6/26/20 at 12:30 p.m., the nurse's note indicated Resident #610 was moved to a different room with Resident #612 for roommate compatibility. Review of the clinical record for Resident #612 (Resident #610's new roommate) revealed [DIAGNOSES REDACTED]. The Minimum Data Set (MDS) assessment dated [DATE] revealed documentation Resident #612 required extensive physical assistance of 2 persons for bed mobility and was totally dependent on 2 staff for transfer. The nurses note dated 7/1/20 indicated Resident #612 had confusion. On 7/1/20 at 1:00 a.m., Registered Nurse (RN) Staff F documented in Resident #610's clinical record in the nurses notes(Resident #610) punched this nurse in the jaw twice, Dr (name) notified of behavior, new orders received, [MEDICATION NAME] 10 mg (milligrams) IM (intramuscular) removed from EDK (emergency drug kit) and administered in R(right) hip with staff assistance; Again encouraged to have a snack and lie down, resident again refused. No other entry was found in the nurses notes until 7/1/20 at 5:45 a.m., when RN Staff F documented Noted resident to be choking (hands around throat) of roommate, was able to remove hands from throat, remove his knee from roommates chest; removed resident from room, 2 CNA's remain with him .transferred to (local hospital). On 7/1/20 at 5:45 a.m., RN Staff F documented in Resident #612's clinical record in the progress notes Responded to resident calling out loudly, residents roommate noted to have hands on throat, knee in chest. 2 CNAs + this nurse able to remove resident's hands, knee + escort him out of the room. Skin check done, neck red, no other injuries noted. Reassured resident that he is safe now. On 7/14/20 at 11:00 a.m., during a telephone interview RN Staff F said Resident #610 was very violent. She was just trying to rub some lotion on his hands when he punched her. She said after she gave him the [MEDICATION NAME] that night (7/1/20) it really did not affect him much. He was still agitated and pacing up and down the hall. She said it was about 5:00 a.m., when the CNA and her put him back to bed but no one stayed with him to monitor. The next thing she knew he was on top of Resident #612 strangling him. She said the ideal thing would have been to place Resident #610 in a private room and assign a sitter, but they didn't, it could have prevented the assault on Resident #612. On 7/14/20 at 9:48 p.m., during a telephone interview CNA Staff K said Resident #610 was always going in and out of other residents' rooms. They tried to keep an eye on him, but it was impossible. She said with only 2 CNAs on the floor and sometimes one, there was no way they could monitor his whereabouts constantly. A lot of times when they tried to get him out of other residents rooms he would get very agitated and violent. She said when that happened, they left him and came back when he was calmer to take him out of the room. She said the night of 7/1/20 Resident #610 punched the nurse twice in the face. He was extremely agitated and violent. The nurse gave him an injection, but no one was monitoring him afterwards. She said the shot the nurse gave him was not strong enough. The resident went in his room and they thought he went to sleep. She said suddenly she heard a noise; it was Resident #612 screaming for help. He cannot

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F 0600 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) defend himself. She rushed to the room and saw Resident #610 had his hands around Resident #612's throat and was squeezing his neck. She said Resident #612 was trying to hold his arms to defend himself but he couldn't. She called the nurse and they finally were able to pull him off Resident #612. She said the Director of Nursing (DON) was in the building and came down. CNA Staff K said they complained several times to the nurses and supervisors about Resident #610, but they didn't do anything. She said it's too late now, he already harmed other residents. On 7/15/20 at 9:35 a.m., after reviewing the clinical record, the psychiatric APRN said when he saw Resident #610 on 6/11/20 he was already agitated. He said the facility did not contact him to inform him of the incidents involving Resident #610 and other residents. He said they contacted the primary care physician who tried to manage his medications, but they never contacted him. He said there is a difference with someone who is easily redirectable but if someone is assaulting other residents, he would have Baker Acted (Florida law for involuntary mental health evaluation) him. He agreed the resident should have been placed on one-on-one supervision to prevent him from attacking other residents.
F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical record, facility policies and procedures, and interview the facility failed to investigate and implement interventions to prevent the misappropriation of narcotic medication, for 1 (Resident #37) of 1 resident identified with medication abnormalities. There were 3 occurrences where narcotic medication was tampered with. The findings included: The facility policy and procedure N-862, Controlled Drug Count (revised 8/22/17), specified, the oncoming and off going shift nurses assigned to the controlled drug cart to be responsible for ensuring the accuracy of the controlled drug count .the 2 nurses to count the number of individualized controlled drugs. a) Look at each controlled drug and verify that the number of individualized controlled drugs matches the number on the Declining Inventory Sheet. b) If the numbers do not match, Stop c) Begin and initial investigation into the root cause d) Notify the Director of Nursing (DON)/designee e) When the DON/designee arrives she/he to continue the investigation to determine the root cause for the discrepancy Review of clinical record for Resident #37 revealed the resident was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. On 4/24/20 the Hospice Physician ordered [MEDICATION NAME] Oral Concentrate, dispense 30 millimeters (ml), give 5 milligram (mg) (0.25 ml) by mouth every 2 hours as needed for acute pain or dyspnea (shortness of breath). On 4/24/20 the Pharmacy delivered the medication. A review of the May 2020 MAR indicated [REDACTED]. Review of the facility timeline documented on 5/12/20 Licensed Practical Nurse (LPN) Staff A discovered 4 ml of medication missing from the unopened bottle of [MEDICATION NAME], during routine shift to shift narcotic counting. LPN Staff A notified the Director of Nursing (DON), and the Pharmacy was notified for a replacement of [MEDICATION NAME]. The replacement [MEDICATION NAME] 30 ml was received by the facility on 5/13/20. A review of the Medication Administration Review (MAR) for April 2020 documented no [MEDICATION NAME] was administered to Resident #37. The timeline documented on 5/29/20 at 7:45 a.m., Unit Manager LPN, Staff D and Unit Manager LPN Staff B, conducted a shift to shift controlled drug count. LPN Staff D observed the bottle of [MEDICATION NAME] contained more of the medication then the full 30 ml bottle the Pharmacy delivered. LPN Staff D removed the cap and noticed a pin size hole in the safety seal of the medication. LPN Staff D notified the Assistant Director of Nursing (ADON) who confirmed the abnormality in the [MEDICATION NAME] bottle. The ADON removed the [MEDICATION NAME] from the medication cart and contacted the pharmacy for replacement. The replacement [MEDICATION NAME] was delivered to the facility on [DATE]. The timeline documented on 6/26/20 LPN Staff D was conducting a shift to shift controlled narcotic medication count with the ADON. The ADON observed the [MEDICATION NAME] bottle was leaking. The two nurses identified a pin size hole in the safety seal of the medication. The DON was notified. The Regional Director of Clinical Services and Administrator were notified, and an investigation was conducted by the facility. A review of the MAR for June 2020 documented no [MEDICATION NAME] was administered to Resident #37 from 6/1/20 through 6/26/20. On 7/13/20 at 3:45 p.m., in an interview the DON said there was no documentation of an investigation on 5/12/20 when 4 ml of [MEDICATION NAME] was identified as missing from the 30 ml bottle on the locked medication cart. The DON confirmed there was no documentation of an investigation conducted on 5/29/20 when a pin size hole puncture in the safety seal of the [MEDICATION NAME] 30 ml sealed bottle was identified. The DON said I was not employed here until 6/1/20 and the previous Administrator was the person responsible to investigate the abnormalities with Resident #37's [MEDICATION NAME] that were identified on 5/12/20 and 5/26/20. On 7/14/20 at 8:15 a.m., in an interview the DON said once the [MEDICATION NAME] was identified as tampered with on 6/26/20, the [MEDICATION NAME] was removed from the medication cart and was discontinued. On 7/14/20 at 9:15 a.m. in an interview Unit Manager LPN Staff D said I was aware of the missing [MEDICATION NAME] from the 1st bottle of Resident #37's medication but was not involved in it. I came into work on 5/29/20 and noticed a discrepancy in the [MEDICATION NAME] count for Resident #37, the bottle looked like there was a lot more in it. I removed the lid and noticed a small pin size hole in the seal and I immediately called the DON, ADON and the Administrator. The medication was removed from the cart and I was told by the Administrator, 'Don't worry about it, just put it to bed.' I volunteered to write a statement and do a drug test, but they declined. The Unit Manager LPN Staff D said the DON said it is nothing at all and a statement and drug test were not needed. Staff D said on 6/26/20 I was assigned to work and I was doing the drug count with the ADON when I noticed the [MEDICATION NAME] Concentrate for Resident #37 was leaking. I took off the cap and there was a pin size hole in the seal. I immediately contacted the Regional Registered Nurse, Administrator and the DON. The DON removed the medication from the cart. Staff D continued to say the Administrator asked me to call a few of the nurses and ask them to write a statement about the medication and to bring it in. I again offered to take a drug test and the Administrator said it was not needed. Staff D said, no one asked me any questions about the [MEDICATION NAME]. On 7/14/20 at 9:39 a.m., in an interview the ADON, said she counted the bottle of [MEDICATION NAME] with LPN Staff D on 6/26/20. The ADON said when I turned it over when we counted, it sprinkled onto me. The ADON said she and LPN Staff D observed a pin hole in the safety seal of the [MEDICATION NAME]. The ADON said the DON was notified and took the [MEDICATION NAME] from the medication cart. The ADON said she was aware the [MEDICATION NAME] bottle was tampered with on 5/12/20 and said, It was my understanding the previous Administrator was doing the investigation. The ADON said once the second bottle of [MEDICATION NAME] was found on 5/26/20 to have a pin hole in the safety seal, the interim DON and ADON were to handle it. The ADON said I was here and still learning, and my role was paperwork and to understand how the process would work. The ADON said it was my job to educate the staff and obtain statements on 6/26/20 regarding the [MEDICATION NAME] tampering. The ADON said I have no documentation of the education provided on 6/26/20 after the 3rd bottle of [MEDICATION NAME] was observed to have a hole in the seal because I just went around to the nurse and educated them, they did not sign anything it was very informal. The ADON said on 6/26/20 I asked LPN Staff D to do the statements from the nurse's since she was more involved. I felt it was appropriate for the LPN to do the statements and education, but I don't know where the documentation that she did is. The ADON confirmed she had no documentation of interventions implemented to prevent the misappropriation of medications. The ADON said I did an in-service on 7/1/20 about loss/theft of medications, acceptance of controlled drugs/misappropriation and drug disposal. A review of the Education In-Service Attendance Record on 7/1/20 documented four Licensed Practical Nurses attended the education. The facility employee list identified 26 licensed nurses employed at the facility. On 7/14/20 at 1:39 p.m., in an interview the Omnicare Pharmacy Consultant said she was not notified that there was a discrepancy with Resident #37's [MEDICATION NAME] on 5/12/20, 5/29/20 and 6/29/20. On 7/14/20 at 4:10 p.m., in an interview the Primary Care Physician said he was not notified that there was a discrepancy with Resident #37's [MEDICATION NAME]. The Physician said he received a phone call from the facility at the end of June 2020 requesting to have the resident's [MEDICATION NAME] discontinued due to non-use. The Physician said he recommended the staff contact Hospice to stop the medication as the Hospice doctor had ordered it. The Physician said the facility contacted me a few days ago and informed me there was a discrepancy with the [MEDICATION NAME] on 6/26/20. The Physician said he was not notified there was a discrepancy on 5/12/20 or 5/29/20 with Resident #37's [MEDICATION NAME]. On 7/14/20 at 5:45 p.m., review of the Hospice Registered Nurse note on 6/26/20 documented, collaborated with skilled nursing facility LPN Staff D, and Hospice Physician regarding Resident #37's [MEDICATION NAME]. Patient was not using so discontinue [MEDICATION NAME]. A review of the Hospice documentation from 5/8/20 through 6/30/20, revealed no documentation the Hospice staff or Physician was notified of the discrepancy with the residents [MEDICATION NAME]. On 6/30/20 documentation on AHCA 5 day report DCF

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HERITAGE PARK REHABILITATION AND HEALTHCARE	**2826 CLEVELAND AVE FORT MYERS, FL 33901**

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 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) notified was (not accepted for investigation) and law enforement notified (no investigation initiated). On 7/15/20 at 6:00 p.m., in an interview the DON confirmed there was no documentation the facility investigated the abnormalities with Resident #37 [MEDICATION NAME]. The DON confirmed there was no documentation the facility implemented interventions to prevent the misappropriation of medications. On 7/16/20 at 11:15 a.m., in an interview, Registered Nurse (RN) Staff C said she was not working on the days Resident #37's [MEDICATION NAME] was tampered with. RN Staff C said, I do not remove the cap from an unopened bottle of [MEDICATION NAME] when counting it because it is unopened, and I have no reason to open it. The RN said, the facility was often short nurses and one or two nurses from a different floor had to come to assist with medication administration on the nursing unit that was short a nurse. RN Staff C said one or two additional nurses would have access to the medication cart and keys but the primary nurse on the floor would be responsible to count the cart at the end of the shift. RN Staff C said, you have no way of knowing who did what because there were different nurses taking the keys to the medication carts.