| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **105462** | A. BUILDING _____ B. WING _____ | **04/29/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **CLEWISTON NURSING & REHABILITATION** | **301 SOUTH GLORIA ST CLEWISTON, FL 33440** |

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 0551<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Give the resident's representative the ability to exercise the resident's rights.**<br><br>Based on record review and interview the facility failed to have a properly executed health care surrogate designation form on file for 1 (Resident #1) of 1 resident reviewed. The findings included: Record review on 4/29/20 at 11:00 a.m., shows health care surrogate designation form filled out and signed 2/11/19. The form indicated In the event that I have been determined to be incapacitated. Record review on 4/29/20 at 11:30 a.m., shows an informed consent for use of bed rails signed by the health care surrogate dated 2/6/19. The form indicated it was a verbal telephone consent. A pneumococcal vaccine evaluation and consent was signed and dated 2/6/19 by the health care surrogate. An influenza vaccine evaluation and consent was signed and dated 2/6/19 by the health care surrogate. Interview on 4/29/20 at 12:55 p.m., with the Assistant Director of Nursing said there was no letter of incapacitation. Interview on 4/29/20 at 12:57 p.m., with the Social Services Assistant said the resident was alert and oriented. He refused to sign his paperwork. |
| F 0842<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review and interview the facility failed to have a complete resident record for 1 (Resident #1) of 1 resident reviewed for appropriate paperwork. The findings included: Review of the clinical record on 4/29/20 at 1:00 p.m., revealed documentation Resident #1 was transferred to a receiving facility on [DATE]. The clinical record did not contain discharge paperwork or transfer form. The clinical record lacked documentation Resident #1 received a bed hold policy. Review of the physician's orders [REDACTED]. A nursing progress note indicated the RN (Registered Nurse) administered [MEDICATION NAME] 2.0 mg IM to Resident #1 on [DATE] at 1:20 p.m. The RN did not document the [MEDICATION NAME] injection on the MAR. Further review of the clinical record showed Resident #1 left the faciity on [DATE] after 7:00 p.m., 6 hours after the nurse administered the [MEDICATION NAME]. There was no indication the resident got [MEDICATION NAME] prior to transfer on [DATE]. Review of the pharmacy transaction record transaction record showed [MEDICATION NAME] was dispensed on 4/22/20 at 7:14 p.m., and [DATE] at 10:57 a.m. On [DATE] at 2:00 p.m., during an interview with the Director of Nursing she confirmed there was no discharge paperwork on file. On [DATE] at 2:00 p.m., The Assistant Director of Nursing said she thought someone had written the orders. She confirmed the resident did receive [MEDICATION NAME] prior to transfer. |

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.