STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106030	A. BUILDING _____ B. WING _____	**07/02/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WESTMINSTER POINT PLEASANT	**1533 4TH AVE W BRADENTON, FL 34205**

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 0760 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility did not ensure the common and safe nursing practice of verifying medications for accuracy prior to administration was performed, and failed to identify four (4) incorrect medications that were administered for one (1) (Resident #1) of three (3) Residents in the sample group. The facility failed to follow their protocols regarding new admission/transfer orders, medication reconciliation, medication administration, and the prevention of medical errors. Findings included: 1. A review of the medical chart for Resident #1 indicates the resident was admitted to the facility on [DATE] at 2:23 p.m., from the facility's Assisted Living Facility (ALF) Towers, with [DIAGNOSES REDACTED]. A review of Admission record for Resident #1 for transfer/admissions process revealed the following paperwork, Resident Medical Information and Medications listed was observed to be on a paper dated January 14, 2006, Resident Medication Administration Record (MAR) and 3008 form provided by the ALF. The following medications read [MEDICATION NAME] 500 mg, [MEDICATION NAME] 125 mcg , [MEDICATION NAME] XL 100 mg, Hydroclorot 25 mg, [MEDICATION NAME] 5mg and [MEDICATION NAME] 20 mg. Further record review of nursing progress notes for Resident #1 revealed no documentation on 4/1/2020 recorded for contacting the resident's daughter to confirm a current medication list, the attending physician or the ALF related to medication verification/reconciliation. Review of the MAR for dated 4/1/2020 and 4/2/2020 was conducted, revealing that there were four (4) medications errors administered to Resident #1 on 4/2/2020 between 06:00 a.m. and 09:00 a.m. Nursing staff administered two (2) incorrect dosages as follows: 1. At 6:00 a.m. [MEDICATION NAME] 125 MCG 1 Tablet given by mouth, instead of the correct dosage of [MEDICATION NAME] 112 MG Tablet. 2. At 9:00 a.m., [MEDICATION NAME] ER 100 MG 1 Tablet given by mouth instead of correct dosage of [MEDICATION NAME] ER 50 mg tablet. The other two (2) other medications administered but not physician ordered was not listed on the transfer MAR from the ALF. They are as follows: 3. [MEDICATION NAME] HCL ER 500 MG 1 Tablet By Mouth Daily administered at 9:00 a.m. 4. [MEDICATION NAME] 20 MG 1 Tablet 1 Tablet by Mouth Daily administered at 9:00 a.m. On 7/02/2020 at 4:06 p.m., an interview was conducted with Staff B, Unit Manager (UM) for Resident #1. Staff B, UM confirmed she noticed medication errors while reviewing Resident #1's physician orders on 4/2/2020. The UM stated here is the paper I used with my writing on it, I put a x on the two medications that she should not have had, and look at the other two, the [MEDICATION NAME] should have been 112 MCG and the nurses already gave it to the her (Resident #1) along with [MEDICATION NAME] 100 mg instead of 50 mg. The order was inaccurate, they looked at the 2006 medications that was given to us when she was transferred to our unit, and it was a transcription error. The UM revealed that the physician was not called for clarification of orders at the time of admission. An investigation was conducted on 4/4/2020 by Staff B (UM). The write up read The medication record used was old and not relevant to this admission, even though it was sent up with her current records, the date was old and the form, and should have been questioned. Procedure is to call physician and confirm the medications and doses at time of admission or by next day if office is not open. This transcription error led to wrong drug and dose administration. On 07/6/2020 at 2:57 p.m. a telephone interview was conducted with Staff A, Licensed Practical Nurse (LPN). Staff A was informed that the DON and UM gave her name and permission to contact her for an interview regarding Resident #1. Staff A was asked about medication order sets that her name was observed to handwritten on, and signature under NURSE: Please Initial the Documentation Record as performed, for Resident #1's transfer admission. Staff A, (LPN) stated I don't recall transposing any orders. I did not have any dealings with the resident on admission, and she came in from the ALF to the admission (transmission) unit. She came in on the 3-11 p.m. shift that I do not work. Staff A, (LPN) revealed that she never had education training or an Inservice related to transcribing medications and or medication errors from the UM. She further indicated she did not remember speaking to the UM about Resident #1's medications or anyone else including the DON. 2. During a phone interview with Resident #1's daughter on 7/6/20 at 1 p.m., the daughter said When I got the bill from the facility, I saw all these medications that were given, and shouldn't have been given. My mother had been off the [MEDICATION NAME] for 2-3 years. The doctor stopped it because my mother lost so much weight, and her blood sugar was within normal parameters. Same thing for the Rosuvastatin and the [MEDICATION NAME], she'd been off those meds for some time. Then I saw that she had been given 100 milligrams (mg) of [MEDICATION NAME] instead of 50 mg, and they gave her 125 mcg (micrograms) of [MEDICATION NAME] instead of 112 mcg. Those were the wrong doses. I called the Nursing home up and told them that these were all wrong medications . She also stated I saw my Mother on March 29, 2020 at the ALF (Assisted Living Facility). She was very lethargic and completely out of it. She was wearing her underwear, a velour jacket, and a blanket on top of her, and she was very sleepy. The weekend nurse agreed with me, and she told me my mother had not been eating, and that my mother had been complaining of stomach pain. Review of the Medication Administration Record (MAR) from 4/2/2020 revealed that [MEDICATION NAME] HCL ER 500 milligrams had been administered to Resident #1 at 9:00 a.m. even though Resident #1 did not eat her breakfast and had less than 25% of her dinner the night before. Review of the Meals/Snack Roster from 4/1/20 through 5/2/20 revealed that Resident #1 did not have breakfast the morning of 4/2/20: Breakfast: percentage eaten: 0% Breakfast fluid intake: 0% Lunch: percentage eaten: 25% Lunch: fluid intake: 200 ml Dinner: percentage eaten: 25% Dinner: fluid intake: 120 ml Snack: percentage eaten: 1-25% Furthermore, a nursing progress note written the night before on 4/1/2020 at 9:58 p.m. revealed Resident remained in bed this evening, appetite poor, ate less than 25% of supper meal. Review of Bristol(NAME)Squibb (BMS) (manufacturer of [MEDICATION NAME] ER/[MEDICATION NAME] XR) dosing and administration for [MEDICATION NAME] showed that [MEDICATION NAME] should be administered with meals. [MEDICATION NAME] XR: Starting dose: 500 mg once orally daily with the evening meal. Under BMS dosage and administration instructions, all indicated that [MEDICATION NAME] and [MEDICATION NAME] extended release should be taken with meals. (https://packageinserts.bms.com/pi/[MEDICATION NAME].pdf). An interview was conducted on 7/2/2020 at 4:10 p.m. with the Unit Manager (Staff B). When asked about the medications, Staff B said When I looked at the medications on the MAR, I saw that the resident was on [MEDICATION NAME] and had been given [MEDICATION NAME]. She was [AGE] years old and hardly eating anything. I asked the doctor if she should be on that, and she said it was discontinued a while back. Review of the Facility's policy titled Medication Administration, revised in June 2019, revealed Policy Explanation and Compliance Guidelines: 14: Administer medication as ordered in accordance with manufacturer specifications. A) Provide the appropriate amount of food and fluid. During the interview on 7/2/20 at 4:10 p.m., Staff B also confirmed that the March ALF MAR and the 2006 medical record document were the papers used to transcribe the admission orders [REDACTED].) Medications: [MEDICATION NAME], [MEDICATION NAME], and [MEDICATION NAME] Allergies and physician information Emergency contacts There was no April 2020 Medication Administration Record (MAR) from the ALF for the morning of 4/1/20, to indicate which medications were given prior to discharge to the Nursing Home in the late afternoon (2:30 p.m. per the Nursing Home nurse progress note written on 4/1/20 at 3:30 p.m.). Review of the Facility policy titled Medication Reconciliation, revised in June 2019, revealed Policy: This facility reconciles medication frequently throughout a resident's stay to ensure that the resident is free of any significant medication errors, and that the facility's medication error rate is less than 5

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 0760 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) percent. Policy Explanation and Compliance Guidelines: 3) Pre-Admission Processes: a. Obtain current medication list from the referral source (i.e.; hospital, home health, hospice, or primary care provider). B. Obtain current medication/admission orders [REDACTED]. Compare orders to hospital records, etc. Obtain clarification orders as needed. C. Transcribe orders in accordance with procedures for admission orders [REDACTED]. Have a second nurse review transcribed orders for accuracy and cosign the orders, indicating the review. Additionally, a review of the Routine Medications Westminster Point Pleasant ALF- March 2020 (handwritten) revealed the following scheduled pain medication, which was given for pain.[MEDICATION NAME] mg (2) tablets by mouth twice a day for pain (dated 3/9/20); 9 a.m. and 5 p.m. [MEDICATION NAME] administered from 3/9/20-3/31/20 (23 days). This order was not transcribed onto to the Nursing Home April 2020 MAR, and the medication was not given as ordered. There were no physician orders to discontinue the Aleve, until 4/2/20. Review of the Hospice physician orders faxed over on 4/2/20 revealed Discontinue [MEDICATION NAME] orders. (Additionally, Staff A, obtained clarification of meds on 4/2/20 and wrote the order for the correct doses of [MEDICATION NAME] (112 mcg) and [MEDICATION NAME] (50 mg)). An interview was conducted on 7/2/2020 at 4:10 p.m. with the Unit Manager (Staff B). When asked if the admitting nurse should have clarified the orders with the doctor before reconciling the medications, Staff B said Yes, but when I spoke to her she said that she just took the handwritten medications from the ALF MAR because they have a different format for orders in the ALF, and she didn't notice the 2006 date on the other sheet. She confirmed that the orders were clarified on 4/2/2020. When asked about the double question marks next to [MEDICATION NAME] on the physician orders, Staff B said Well, I saw that she was [MEDICATION NAME] pain while she was in the ALF. The doctor was called, and [MEDICATION NAME] discontinued. When a resident is admitted , the procedure is to call the physician and confirm the medications and doses. It was a transcription error that led to a medication error. During a phone interview with Resident #1's daughter on 7/6/2020 at 1 p.m., the daughter was asked if she was informed by the Nursing Home that [MEDICATION NAME] been discontinued. The daughter stated No, I didn't know until I received the bill for the medications. Review of the Facility policy titled Medication Orders, revised in June 2019, revealed Policy: This facility shall use uniform guidelines for the ordering of medication. 4) Documentation of Medication Orders: B. Clarify the order. F. When a new order changes the dosage of a previously prescribed medication, discontinue the previous entry by writing DC'd and the date. G. Enter the new order on the MAR. H. Notify resident's sponsor/family of the new medication order. 5) Specific Procedures for Medication Orders: C. Written Transfer Orders (sent with a resident by a hospital or other health care facility) .If the order is unsigned, or signed by another physician, or the date is other than the date of admission, the receiving nurse should verify the order with the current attending, before medications are administered. The nurse should document verification on the admission order record, by entering the time, date, and signature. Example: Order verified by the phone with Dr. Smith/M.(NAME) R.N. Review of the Facility's policy titled Medication Errors, revised in June 2019, revealed Policy: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by ensuring residents receive care and services safely in an environment free of significant medication errors. Policy explanation and Compliance Guidelines: 1) The facility shall ensure medications will be administered as follows: A) according to the physician's orders. B) Per manufacturer's specifications regarding the preparation and administration of the drug or services. 7) To prevent medication errors and ensure safe medication administration, nurses should verify the following information: A. Right medication, dose, route, and time of administration. B. right resident and right documentation.