| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **105358** | A. BUILDING _____ B. WING _____ | **07/21/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **ST CATHERINE LABOURE MANOR, INC** | **1750 STOCKTON ST JACKSONVILLE, FL 32204** |

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 0658<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | **Ensure services provided by the nursing facility meet professional standards of quality.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review and interviews the facility failed to ensure qualified staff reconcile new medication orders, order medications and administer all medications as ordered, assess residents with change in respiratory status, notify physician of changes, document and communicate sudden onset change in condition and perform oxygen saturation levels to further assess acute respiratory onset resulted in the death of 1 of 1 sampled residents. (Resident #1) The findings include: Professional Standard of Care is defined in Chapter 766.102 as the prevailing professional standard of care for a given health care provider shall be that level of care, skill, and treatment which in light of all relevant surrounding circumstances is recognized as acceptable and appropriate by reasonably prudent similar health care providers. The Florida Nurse Practice Act, Chapter 464.003 defines the practice of professional nursing as the performance of those acts requiring substantial specialized knowledge, judgment, and nursing skill based upon applied principles of psychological, biological, physical, and social sciences which shall include, but not limited to: the administration of medications and treatments as prescribed or authorized by a duly licensed practitioner ' practice of practical nursing as the performance of selected acts, including the administration of treatments and medications, in the care of the ill, injured or informed and the promotion of wellness, maintenance or health, and the prevention of illness of others under the direction of a registered nurse, a licensed physician, a licensed osteopathic physician or a licensed dentist. Review of the physician orders [REDACTED].#1 revealed all medications were entered and ordered by Licensed Practical Nurse LPN (Emp B) on [DATE]. Further review of the December and January MAR indicated [REDACTED]. There was no order found to discontinue the Eliquis. Review of the nursing notes did not indicate any changes to medications. An interview was conducted with Assistant Director of Nursing (ADON) at 2:15pm, she was asked to review the December and January Medication Administration Record [REDACTED]. When asked when was the error discovered she wasn't sure, but it was after he went to hospital. Review of the nursing notes from [DATE]-[DATE] revealed nurses only documented on ,[DATE], ,[DATE], ,[DATE], ,[DATE] and [DATE]. There were no daily assessments of his condition, change in condition or care and treatment provided by nursing. There was no documentation regarding the administration of oxygen or obtaining oxygen saturation levels to assess respiratory status. Also there was no documentation for the indwelling urinary catheter, catheter care or monitoring output and signs and symptoms of infection. Review of the physician orders [REDACTED]. On [DATE] [MEDICATION NAME] 1 mg daily for urine retention,[MEDICATION NAME] mg every third day for UTI on [DATE] and [MEDICATION NAME] 40 mg IM on [DATE]. There was no nursing documentation of new orders, urinary tract infection, [MEDICAL CONDITION] or need for [MEDICATION NAME] IM for increased swelling of right arm. During an interview with the ADON on [DATE] at 4:10pm she confirmed there was no documentation regarding oxygen, urinary catheter, urinary tract infection, [MEDICAL CONDITION] or change in condition. She was asked what was the facility policy regarding how often nurses should document on residents receiving skilled services, she said at a minimum every 24 hours and whenever there are changes in condition. Each shift charts vital signs, meal intake and change in condition. When there was a change in condition each shift must chart for a minimum of 72 hours after the change was noted or until stable. Review of the physical therapy (PT) note date [DATE] revealed Res #1 was very short of breath during activity and reported something was wrong with his nasal cannula. Oxygen was at 3 liters per minute when he arrived at gym. His oxygen saturation level was 87% and heart rate 167, he was doing a lot of mouth breathing. He reported he was very cold and covered with blanket and returned to unit. The therapist conferred with Registered Nurse (EMP A) regarding his vital signs. PT note dated [DATE] revealed Res #1 demonstrated increased swelling to right upper arm with leaking fluid through skin. Nursing (unit manager )was notified about right arm and labored breathing. PT note dated [DATE] revealed oxygen saturation levels and heart rate were monitored, oxygen saturation levels lower secondary to mouth breathing. Also noted Res #1 started on [MEDICATION NAME] due to excessive right upper arm swelling The RN (Emp A ) notified of the vital signs and labored breathing. Review of the nursing notes found no documentation that changes in condition reported by therapist on ,[DATE], ,[DATE], and ,[DATE] were followed up. There were no assessments or vital signs performed and no notification to the physician. During an interview with ADON on [DATE] at 4:40pm, she was asked to review the PT notes of ,[DATE], ,[DATE] and ,[DATE]. She was then asked to review the nursing notes for those days. When asked if the nurses had documented communication with therapists on those days, she said no. Was the physician notified of the changes, she said no however the physician visited on [DATE]. When asked if the nurse documented the physician visit and any new orders, she said no. On [DATE], Resident #1's family requested oxygen saturation level be checked as he was very short of breath. RN (Emp A) documented at 1:30pm oxygen saturation level was 72% and was on 4 liters of oxygen. The physician notified and ordered venous Doppler of right arm and [MEDICATION NAME] 40 mg IM. There was no assessment of respiratory condition, oxygen saturation or vital signs after administration of [MEDICATION NAME]. Venous Doppler showed [MEDICAL CONDITION] of right brachial vein. At 4:30pm blood sugar level was 203 and insulin coverage given. No documentation of respiratory assessment or oxygen sat level. At 5:40pm Certified Nursing Assistant (Emp D) found him unresponsive with no vital signs found. Emp D informed the RN (EMP A). 911 called and CPR initiated. When EMS arrived Res #1 was intubated and immediately transported to hospital. He died on [DATE]. |
| F 0684<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | **Provide appropriate treatment and care according to orders, resident's preferences and goals.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record reviews and interviews the facility failed to reconcile admission orders [REDACTED]. On [DATE] the facility census was 143. There were 34 residents admitted in past 30 days and were at risk AND Immediate Jeopardy (IJ) at a scope of J (isolated) was identified at 5:15 PM on [DATE], which is ongoing. On [DATE] at 8:55 PM, the Administrator was notified of the IJ determination. The findings include: Record review for Resident #1 revealed [AGE] year old male admitted on [DATE] with [DIAGNOSES REDACTED]. He was alert with confusion. Required extensive assist with activities of daily living except for independence with eating. He was admitted with orders for wound care for surgical site left foot and oxygen 3 liters as needed. He was also ordered physical and occupational therapy five times a week. The admission nursing assessment dated [DATE] indicated there was a urinary catheter, there were no orders found for catheter or catheter care. The following medications were ordered upon admission: Eliquis 5 mg twice a day (anticoagulant to treat [MEDICAL CONDITION]), [MEDICATION NAME] sliding scale insulin, Magnesium 400 mg daily, Potassium chloride ER 20 meq 2 tablets daily, [MEDICATION NAME] 0.4 mg daily, [MEDICATION NAME] 50 mg daily, Pantoprazole 40 mg daily, [MEDICATION NAME] 125 mcg daily, [MEDICATION NAME] 100 mg twice day, [MEDICATION NAME] ER 90 mg daily, [MEDICATION NAME] 0.25 mcg daily and Atorvastatin 40 mg daily.<br>Review of the physician orders [REDACTED]. There was no order found to discontinue the Eliquis. Review of the nursing notes did not indicate any changes to medications. An interview was conducted with Assistant Director of Nursing (ADON) at 2:15pm, she was asked to review the December and January Medication Administration Record [REDACTED]. When asked when was |

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **105358** | A. BUILDING _____ B. WING _____ | **07/21/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **ST CATHERINE LABOURE MANOR, INC** | **1750 STOCKTON ST JACKSONVILLE, FL 32204** |

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 0684<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | (continued... from page 1)<br>the error discovered she wasn't sure, but it was after he went to hospital. Review of the nursing notes from [DATE]-[DATE] revealed nurses only documented on ,[DATE], ,[DATE], ,[DATE], ,[DATE] and [DATE]. There were no daily assessments of his condition, change in condition or care and treatment provided by nursing. There was no documentation regarding the administration of oxygen or obtaining oxygen saturation levels to assess respiratory status. Also there was no documentation for the indwelling urinary catheter, catheter care or monitoring output and signs and symptoms of infection. Review of the physician orders [REDACTED]. On [DATE] [MEDICATION NAME] 1mg daily for urine retention,[MEDICATION NAME] every third day for UTI on [DATE] and [MEDICATION NAME] 40 mg IM on [DATE]. There was no nursing documentation of new orders, urinary tract infection, [MEDICAL CONDITION] or need for [MEDICATION NAME] IM. During an interview with the ADON on [DATE] at 4:10pm she confirmed there was no documentation regarding oxygen, urinary catheter, urinary tract infection, [MEDICAL CONDITION] or change in condition. She was asked what was the facility policy regarding how often nurses should document on residents receiving skilled services, she said at a minimum every 24 hours and whenever there are changes in condition. Each shift charts vital signs, meal intake and change in condition. When there was a change in condition each shift must chart for a minimum of 72 hours after the change was noted or until stable. Review of the physical therapy (PT) note date [DATE] revealed Res #1 was very short of breath during activity today and reported something was wrong with his nasal cannula. Oxygen was at 3 liters per minute when he arrived at gym. His oxygen saturation level was 87% and heart rate 167, he was doing a lot of mouth breathing. He reported he was very cold and covered with blanket and returned to unit. The therapist conferred with Registered Nurse (EMP A) regarding his vital signs. PT note dated [DATE] revealed Res #1 demonstrated increased swelling to right upper arm with leaking fluid through skin. Nursing (unit manager )was notified about right arm and labored breathing. PT note dated [DATE] revealed oxygen saturation levels and heart rate were monitored, oxygen saturation levels lower secondary to mouth breathing. Also noted Res #1 started on [MEDICATION NAME] due to excessive right upper arm swelling The RN (Emp A ) notified of the vital signs and labored breathing. Review of the nursing notes found no documentation that changes in condition reported by therapist on ,[DATE], ,[DATE], and ,[DATE] were followed up. There were no assessments or vital signs performed and no notification to the physician. During an interview with ADON on [DATE] at 4:40pm, she was asked to review the PT notes of ,[DATE], ,[DATE] and ,[DATE]. She was then asked to review the nursing notes for those days. When asked if the nurses had documented communication with therapists on those days, she said no. Was the physician notified of the changes, she said no however the physician visited on [DATE]. When asked if the nurse documented the physician visit and any new orders, she said no. On [DATE], Resident family requested oxygen saturation level be checked as he was very short of breath. RN (Emp A) documented at 1:30pm oxygen saturation level was 72% and was on 4 liters of oxygen. The physician notified and ordered venous Doppler of right arm and [MEDICATION NAME] 40 mg IM. There was no assessment of respiratory condition, oxygen saturation or vital signs after administration of [MEDICATION NAME]. Venous Doppler showed [MEDICAL CONDITION] of right brachial vein. At 4:30pm blood sugar level was 203 and insulin coverage given. No documentation of respiratory assessment or oxygen sat level. At 5:40pm Certified Nursing Assistant (Emp D) found him unresponsive with no vital signs found. Emp D informed the RN (EMPA). 911 called and CPR initiated. When EMS arrived Res #1 was intubated and immediately transported to hospital. He died on [DATE]. Review of the adverse incident report filed by Risk Manager (RM) on [DATE] revealed the incident of Res #1 occurred on [DATE]. An investigation was conducted on [DATE]. Analysis of the incident revealed there was failure to correctly order admission medications, no documentation to support this was addressed by nursing and elevated to physician. Anticoagulant medication Eliquis entered on admission but never administered because of an order entry error. Medication reconciliation was not completed until 20 days post admission, failed to recheck oxygen saturation levels after administration of [MEDICATION NAME] 40 mg IM. Resident #1 died at hospital on [DATE]. The final [DIAGNOSES REDACTED]. An interview was conducted with Res #1's physician on [DATE] at 1:15pm. He was asked if he had been notified of Res #1 not receiving Eliquis during his stay, he said it was brought to his attention after the fact by the Medical Director, not the nursing staff. He said he did not know why he was not getting the medication. It was his understanding that Resident #1 was getting the medication as he was supposed to. He stated I can not tell you for sure where the disconnect was. |

| | |
|---|---|
| F 0760<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | **Ensure that residents are free from significant medication errors.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review and staff interviews the failed to ensure there was a system in place to reconcile all new admission orders [REDACTED]. (Resident #1). On 7/16/20 the facility census was 143. There were 34 residents admitted in past 30 days and were at risk AND Immediate Jeopardy (IJ) at a scope of J (isolated) was identified at 5:15 PM on 7/16/20, which is ongoing. On 7/21/20 at 8:55 PM, the Administrator was notified of the IJ determination. The findings include: Record review for Resident #1 revealed [AGE] year old male admitted on [DATE] with [DIAGNOSES REDACTED]. He was alert with confusion. Required extensive assist with activities of daily living except for independence with eating. He was admitted with orders for wound care for surgical site left foot and oxygen 3 liters as needed. The admission nursing assessment dated [DATE] indicated there was a urinary catheter, there were no orders found for catheter or catheter care. The following medications were ordered upon admission: Eliquis 5 mg twice a day (anticoagulant to treat [MEDICAL CONDITION]), [MEDICATION NAME] sliding scale insulin, Magnesium 400 mg daily, Potassium chloride ER 20 meq 2 tablets daily, [MEDICATION NAME] 0.4 mg daily, [MEDICATION NAME] 50 mg daily, Pantoprazole 40 mg daily, [MEDICATION NAME] 125 mcg daily, [MEDICATION NAME] 100 mg twice day, [MEDICATION NAME] ER 90 mg daily, [MEDICATION NAME] 0.25 mcg daily and Atorvastatin 40 mg daily. Review of the physician orders [REDACTED]. The order for Eliquis had a start date of 12/20/19 and stop date 12/21/19. There was no order found to discontinue the Eliquis. Review of the nursing notes did not indicate any changes to medications. An interview was conducted with Assistant Director of Nursing (ADON) on 7/20/20 at 2:15pm, she was asked to review the December and January Medication Administration Record [REDACTED]. When asked when was the error discovered she wasn't sure, but it was after he went to the hospital. She was asked who was responsible to reconcile new admission orders [REDACTED]. If a medication was not received from pharmacy what was the protocol. The pharmacy was to be called to inquire as to why the medication had not been sent and call physician if there would be delay in obtaining the medication. Also the unit managers were to check all admission orders [REDACTED]. When asked if that had been done, she said not consistently. She was asked what was the issue with order entry, she said there had been issues with medications entered into the computer and when the orders get to the pharmacy. She said if a medication was ordered and was not sent by pharmacy the nurse would need to enter the order again, however the medication had to be discontinued before entering order again. The problem that was happening was that when the order was discontinued and re-entered, the new order did not show up on pharmacy side. The pharmacy computer showed as discontinued and medication was not dispensed. An interview was conducted with Unit Manager (Emp F) on 7/21/20 at 10:37 am. She was asked if she was aware of the issue regarding Resident #1 not receiving Eliquis while in the facility. She said she was made aware after he was transferred to the hospital. She was asked how did the error occur. She responded for some reason it was discontinued from the Medication Administration Record [REDACTED]. We didn't know the pharmacy could not see it on their end. The pharmacy could not see where the medication was put back on the MAR. The pharmacy could not see the orders were duplicated In order to correct duplication, one of the entries for the medication had to be discontinued. However, once the discontinue order was entered, the order was canceled at pharmacy and medication was not sent. She stated she did not realize the issue until it happened to her about a month later. She had entered a new order for Res #5 for Trazadone and ordered from pharmacy. When the medication did not arrive, she called the pharmacy and was told the order was discontinued by Emp F, she stated that was me and I did not discontinue the medication order. The pharmacy said they could not see duplication order, only the discontinued order. She immediately thought of Res #1 and realized what had happened and why he had not received his Eliquis. She was asked if the issue was brought to the attention of administration and what was done. She said there was a meeting but does not remember when. She said she did discuss with other unit managers. When asked if there had been in-service training with facility and pharmacy to rectify the issue, she said not that she was aware. An interview was conducted via phone with nurse (Emp C) on 7/21/20 at 12:13pm. She was asked if there had been any issues with entering medications and not receiving from the pharmacy. She said she has notified the administration about the frustration with the orders (missing medications, duplicate orders) numerous times. She was asked if the issue was addressed. She said she was not sure what they are doing about it. There's a glitch in the system. It's time consuming because you have to wait for the pharmacy to answer and wait for the medication when it should have been delivered after the ordered entered. An interview was conducted with Director of Nursing (DON) on 7/21/20 at 2:45pm. She was asked if she was aware of the incident related to Res #1 on 1/19/20. She stated she was not employed at the facility at the time. She started in March of this year. When asked if she was made aware of issues with glitches in the computer system related to order entry and the pharmacy, she said no. She added that the facility would be changing |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105358 | A. BUILDING _____ B. WING _____ | 07/21/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| ST CATHERINE LABOURE MANOR, INC | 1750 STOCKTON ST JACKSONVILLE, FL 32204 |

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<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | (continued... from page 2)<br>pharmacies next week. When asked if the facility would continue to use current software system, she stated yes. She was asked if the new pharmacy had been made aware of issues with order entries, not that she knew but would bring it up. An interview was conducted with the Consultant Pharmacist at 4:55pm. She was asked what dates she reviewed medications for Res#1. She said all residents are reviewed within 72 hours of admission. He was admitted on [DATE]. His orders came to the pharmacy on 12/22/19 and she reviewed his medications on 12/24/19. He was discharged previous to her next monthly review. She was asked if Res #1 had Eliquis ordered. She said there was no record for Eliquis for him from 12/22/19 forward. The pharmacy had no record at all. The pharmacy never received a duplicate order or discontinued order. She had pharmacy check and there was not even an incomplete order. On the facility's physician's orders [REDACTED]. It was discontinued in Matrix before we ever received his orders on 12/22/2019. The nurses are expected to contact the pharmacy if a medication is not in or if there's a problem not re-order and discontinue it. When she did his review, she didn't see the [DIAGNOSES REDACTED]. She said she could not see the hospital discharge summary or any of that information. When she did the reviews, she looked for any omissions, duplications, chronic conditions anything high risk. In his case we just never got the order. |
| F 0867<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | **Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record reviews and staff interviews and the facility's policy and procedure for Quality Assurance Performance Improvement (QAPI), the facility failed to ensure quality assurance monitoring of facility processes related to adverse events and to ensure identification of potential significant problems. The lack of follow up to adverse events related to reconciling new medications, ordering medications and administering medications as ordered, assessing residents for change in condition and notifying physician resulted in the death of one resident. (Resident #1) Immediate Jeopardy (IJ) at a scope of J (isolated) was identified at 8:55pm on [DATE], the Administrator and Director of Nursing was notified of the IJ determination. The findings include: Review of the records for Resident #1 revealed upon admission on [DATE], he was ordered Eliquis 5 mg twice a day for [MEDICAL CONDITION]. The admitting nurse Emp B entered the orders into the computer and ordered all new medications. Review of the Medication Administration Record [REDACTED]. The medication had not been discontinued, however the nurses did not follow up and Res #1 never received the medication to prevent blood clots. The facility was not aware that Res#1 had not been administered the medication until after he was transferred to the hospital on [DATE]. On [DATE], Resident #1's family requested oxygen saturation level be checked as he was very short of breath. RN (Emp A) documented at 1:30pm oxygen saturation level was 72% and was on 4 liters of oxygen. The physician notified and ordered venous Doppler of right arm and [MEDICATION NAME] 40 mg injection. There was no assessment of respiratory condition, oxygen saturation or vital signs after administration of [MEDICATION NAME]. Venous Doppler showed [MEDICAL CONDITION] of right brachial vein. At 4:30pm blood sugar level was 203 and insulin coverage given. No documentation of respiratory assessment, oxygen sat level or if there was decrease in swelling of right arm At 5:40pm Certified Nursing Assistant (Emp D) found him unresponsive with no vital signs found. Emp D informed the RN (EMPA). 911 called and CPR initiated. When EMS arrived Res #1 was intubated and immediately transported to hospital. He died on [DATE]. Review of the adverse incident report filed by previous Risk Manager (RM) on [DATE] revealed the incident regarding Res #1 occurred on [DATE]. An investigation was conducted on [DATE]. The analysis of the incident revealed the following: there was failure to correctly order admission medications, no documentation to support this was addressed by nursing and elevated to physician. Anticoagulant medication Eliquis entered on admission but never administered because of an order entry error. Medication reconciliation was not completed until 20 days post admission, failure to recheck oxygen saturation levels after administration of [MEDICATION NAME] 40 mg IM. Resident #1 died at hospital on [DATE]. The final [DIAGNOSES REDACTED]. An<br>interview was conducted RM, Assistant Director of Nursing (ADON), Staff Development Coordinator (SDC) and Administrator, on [DATE] at 12:50pm. The RM stated was not employed at the time of the incident. Administrator was asked if Quality Assurance/Performance Improvement (QAPI) meeting was convened after the incident regarding Res #1. He said there was a meeting on [DATE] via phone with himself, Medical Director, attending physician, ADON, RM and corporate risk manager. The Administrator was asked how the facility made aware of Res #1 not been administered Eliquis for [DATE]-[DATE]. He stated I believe when Resident was transferred to hospital, but we are not sure, I'm still looking into that. He was asked if an action plan was initiated following the incident, he said there was and would provide a copy. Review of the action plan initiated by the facility included: root cause: medical record review: solution, medical record review to be completed less than 24 hours post admission, unit manager to review all medical records. Matrix care order entry, physician notification and recognizing high risk conditions. The SDC was asked what training, education, in services, competencies were conducted regarding the action plan, she said she would provide all training she had conducted. Review of the in=service materials provided revealed the only training provided was related to CPR and care planning. There was no training or education to address issues with order entries in computer causing medication errors and failure to administer medications, change in condition, notification to physician regarding changes and appropriate assessment of residents with high risk conditions. An interview was conducted with Medical Director on [DATE] at 11:59 am via telephone. When asked if he had been notified of the incident regarding Res #1 he said the administrator notified him. After he was notified he reviewed the patient chart. He stated from what I gathered when the doctor came to see the patient the paper chart was not available so he could not review the chart. The paperwork the doctor had did not have the Eliquis on it. I'm not sure if it's a data entry error or not. I spoke to medical records and told them that the information needs to be scanned in so that the doctor has access to all information when he sees the patients. He also said that when the attending physician saw the patient, it was not scanned in, so he was not aware of that medication. He further added he review all of the records and talked to the doctor and the nurses. The Administrator told me that there was an error. He said he was involved in the plan of action. He told the administration that the nurse needs to call the doctor and go over every medication with the doctor. He stated I did a lot of education. I talked to the charge nurse and the patient's nurse. He said the unit clerk is supposed to put the information in, and the nurse checks it. I talked to both of them and the DON and Medical Records. The nurse has to review all of the Unit Clerks entries. When asked if he was aware there was an issue with the how the orders were entered into the computer and what information the pharmacy received. He said he was not aware there was an issue with the pharmacy not receiving all orders. An interview was conducted with administrator at 12:50pm. He was asked if he had found out how the facility was made aware of the medication error for Res#1. He said the hospital called the facility. When asked who received the call from the hospital, he stated he did not know, maybe risk manager. Ask what date the call came he did not know. When he was made aware he notified medical director and ADON who was the acting DON at the time. Medical director notified the attending physician. An interview was conducted with Res #1's physician at 1:15pm. He was asked what was the expectation of the nursing staff when a resident has not received medications as ordered. He expected to be notified immediately. He said it was brought to his attention by the Medical Director not the nursing staff that Res #1 did not receive Eliquis. He said the Medical Director told him that it was brought to his attention after the fact. He said he did not know why he wasn't getting it. He stated it was his understanding that he was getting the medications as he was supposed to. I cannot tell you for sure where the disconnect was. An interview was conducted with Director of Nursing (DON) on [DATE] at 2:45pm. She was asked if she was aware of the incident related to Res #1 on [DATE]. She stated she was not employed at the facility at the time. She started in March of this year. When asked if she was made aware of issues with glitches in the computer system related to order entry and the pharmacy, she said no. She added that the facility would be changing pharmacies next week. When asked if the facility would continue to use current software system, she stated yes. She was asked if the new pharmacy had been made aware of issues with order entries, not that she knew but would bring it up. During an interview with the Administrator at 2:53pm he was asked if he was aware of the problem with order duplication and discontinue errors with the pharmacy, he said we can start tracking and do an audit of that. During an interview with SDC, on [DATE] at 3:20pm she confirmed there was no training regarding Matrix care, notification of change to MD or signs and symptoms of high risk conditions. She stated during the interview that she was not aware of the incident regarding Res #1, she said she was not included in morning meetings and not kept informed of any changes. She said all her time is devoted to orientation that includes large HR component. She spends very little time on the units. She was told of the need to review CPR and conduct mock code drills, which she did provide. She was unaware of the issues with the computer system regarding order entry and she was the person training all new nurses on the Matrix care software At the time of the survey, |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **105358** | A. BUILDING _____ B. WING _____ | **07/21/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **ST CATHERINE LABOURE MANOR, INC** | **1750 STOCKTON ST JACKSONVILLE, FL 32204** |

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 0867<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | (continued... from page 3)<br>the facility had no monitoring/audit process for ensuring nursing staff were appropriately trained and competent to provide necessary care to the facility residents. Staff interviews revealed ongoing issues with order entry, ordering and obtaining medications timely with no follow up from nursing administration to ensure issues were resolved to prevent further incidents of residents not being administered medications. There was no monitoring or auditing by nursing administration regarding reconciling and ordering medications to ensure all medications were administered as prescribed, even after the death of Res #1. |