STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105987	A. BUILDING _____ B. WING _____	02/27/2020

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HUNTERS CREEK NURSING AND REHAB CENTER	14155 TOWN LOOP BLVD ORLANDO, FL 32837

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted on - . Hunters Creek Nursing And Rehabilitation Center was not in compliance with 42 CFR Part 483 and 488, requirement for Long-Term Care Facilities.	F 000		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide care in a timely manner for 1 of 3 residents reviewed for activities of daily living, (ADL) of a total sample of 50 residents, (#33). Findings: Resident #33 was admitted to the facility on with her most recent readmission on . Her diagnoses included , and following unspecified affecting right side and generalized . The quarterly minimum data set (MDS) assessment with assessment reference date revealed the resident's cognition was moderately , with a brief interview of mental status ( ) score of . The resident required for bed mobility, , toilet use, and personal hygiene, and was always of	F 677	1. Resident #33 received of care at approx. 8 am on . Resident #33 skin check was completed on and revealed no adverse affects from delay in the care. APRN assessed resident #33 on for , , negative effects from delay in care and assessed none present. LPN D was educated regarding the timeliness of delivery of care. 2. Resident audit conducted by DON/ designee on to identify other residents requesting care within timely delivery and found no further concerns. 3. Staff educated by SDC/ designee regarding the importance of answering calls in a timely manner to meet resident's needs. 4. Random weekly audits will be conducted by the DON/ designee. The results of these audits will be presented at the monthly QA committee for further	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed /2020

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 677	Continued From page 1 and . . . . On ..... at 9:00 AM and at 4:11 PM, resident #33 stated that last night, she was wet and had a . . . movement, and used the call light to call for assistance. She said she put her call light on, waited for half an hour, with no response. She said she then started calling out, "hello, hello." After 10 minutes of calling out, someone came into her room. The resident stated she told staff that she was covered in . and needed to be changed. She said the staff member told her to wait a minute as she would get someone to assist. The resident stated that she was not changed until this morning on at about 9:30 AM. at 5:12 PM, the Captiva Unit Manager, (UM) stated that a grievance was placed by the resident this morning regarding the incident. The UM stated that the facility had cameras that monitored the hallways. She further stated that video footage could be reviewed to see if call lights were on, and when staff responded to the call lights. On . . . . . at 10:22 AM, the Administrator and Director of Nursing (DON) stated that a grievance was started on . . . . regarding resident #33's concern of not being changed in a timely manner. The Administrator said the resident told the Social Services Director (SSD) that the incident happened sometime after 3 AM on . . . . . . Camera footage for from 3 AM-6:30 AM was viewed with the Administrator and the DON. Footage showed licensed practical nurse (LPN) D entered resident #33's room at 3:17 AM and came out of the room at 3:18 AM. At 4:15 AM, certified nursing assistant (CNA) E went into	F 677	review and recommendations for three months and as deemed necessary thereafter.	

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F 677	Continued From page 2	F 677		

resident's room. As per the DON, CNA E stated she asked the resident if she wanted to be changed, and the resident stated she was fine. At 4:46 AM, LPN D went into the resident's room. The DON stated, that LPN D told her the resident's call light was on, and the resident asked to be changed. Both the Administrator verified that there was a period of an hour between the time when LPN D responded to the resident's call light, and when the CNA went into the resident's room. The DON said LPN D reported that she turned the resident's call light off, came out of the room, but forgot to tell the CNA. LPN D did not provide care to the resident. The DON stated that the 7AM- 3 PM CNA F said the resident was wet when she changed her at approximately 8 AM.

On . . . . . at 11:18 AM, registered nurse (RN) G stated that resident #33 was able to make her needs known, and if the resident told him she was wet, he would expect the resident to be changed within . . minutes.

On . . . . . at 5:00 PM the DON stated, that when a resident said they were soiled, someone needed to go in and get care done as soon as possible.

On at 5:53 PM, LPN D stated that she worked with resident #33 on . . . . . on the 11PM-7AM shift. LPN D stated she answered the resident's call light, and the resident told her that she was wet. LPN D said she told the resident she would let the CNA know. LPN D stated resident#33 was very alert and used the call light when she needed something. LPN D stated she saw CNA E go into the resident's room, but she did not see if the CNA changed the resident. LPN

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F 677	Continued From page 3 D sated, that her expectation was that the resident should be changed immediately. LPN D said she did not change the resident. She reported that the CNA did not inform her that when she approached the resident, the resident stated that she was fine. On at 9:10 AM, the Social Services Director (SSD) stated that a grievance was started on resident #33 on . She said resident #33 stated she was "soaking wet" and had put her call light on around 3 AM on . She added that a staff came in, said she would be right , turned off the call light, but did not come . The resident reported she got changed by another CNA at 9AM. The SSD stated resident #33 was alert, oriented x 2 and able to make her needs known. On at 10:54 AM, the DON and Administrator stated that care was not provided to resident #33 in a timely manner. A review of the resident's care plan for " Focus" revised on included interventions to "monitor for episodes of and provide care after episode of ; maintain privacy and dignity during care." The facility's policy and procedure "Personal Care Needs Policy" with revision date read, "A patient who is unable to carry out activities of daily living receives the necessary services to maintain personal hygiene."	F 677		
F 686 SS=D	Treatment/Svcs to Prevent/Heal CFR(s): 483.25(b)(1)(i)(ii)	F 686		

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F 686	Continued From page 4 §483.25(b) Skin Integrity §483.25(b)(1) Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent and does not develop unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent and prevent new from developing. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to implement interventions to promote healing of a for 1 of 1 resident reviewed for , of a total sample of 50 residents, (#7). Finding Resident #7 was admitted to the facility on and readmitted on . Her diagnoses included 's , to right , left , left , right , right , and . The resident's current physician orders dated read, apply to right medial everyday shift, cleanse with normal , dry, apply , follow by and cover with dry . is a "product used to help the healing of and skin ...It works by helping to break up and remove skin and tissue."	F 686	1. Physician order regarding for healing were obtained on for resident #7. ARNP discontinued the order for on . 2. Facility audit conducted by DON/ designee on to review care consults within the last 2 weeks. No further discrepancies were noted. 3. Nursing staff educated by SDC/ designee to review and address care consult recommendations. 4. Random weekly audits will be conducted by the DON/designee. The results of these audits will be presented at the monthly QA committee for further review and recommendations for three months and deemed necessary thereafter.	

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F 686	Continued From page 5 (WebMD) The quarterly minimum data set (MDS) assessment with assessment reference date . . . . , revealed that the resident was rarely/never understood, and had total dependence on staff for all activities of daily living. The resident was assessed as being frequently . . . . . of . . . . . and . . . . . The " . . . . Rounds" note dated . . . . . read, "Resident was seen by . . . . care MD (medical doctor) for . . . . . of the right medial . . . . 3.4 x 2.5 (centimeters)...recommend . . . , (. . . . .) due to resident constant moisture to promote . . . . healing." On . . . . . Rounds documentation read, "Resident was seen by . . . . care MD for . . . . . of the right medial . . . 2.5 x 4.7 x 0.8 ...Debridement was performed without any complications ...recommend . . . due to resident constant moisture to promote . . . . healing ..., notified MD orders was given . . . . for dribbles.." "A . . . . is a thin, sterile tube inserted into the . . . . . to drain . . . ." (eMedicineHealth) On . . . . . the . . . . . Rounds note read, " Resident was seen by . . . . care MD for . . . . . of the right medial . . . . 4 x 3.8 x1 ... Debridement was performed...skin irritation superficial breakdown due to heavy wetting." The resident's " . . . . Evaluation & Management Summary" dated . . . . . read, "She has an . . . . . (due to necrosis) of the right medial . . . . . for at least 2 days duration." Measurements were, 3.4 cm (centimeter) x 2.5 x	F 686		

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F 686	Continued From page 6	F 686		

not measurable, and the [redacted] had 25% [redacted]. Debridement was performed to "remove tissue and establish margins of viable tissue .... recommend [redacted] for [redacted] healing.". Documentation indicated, that "The clinical documentation for this consultation was made available to the referring physician ...also made available to the skilled nursing facility at any time for placement in the skilled nursing facility record."

A handwritten note documented on the " Evaluation & Management Summary" for [redacted] read, "Recommendation noted for placement of [redacted]-will reassess [redacted] on next visit. D/W (discuss with) ID ([redacted]) but due to recent [redacted] we will wait on [redacted]."

On [redacted] the [redacted] measurements were 2.5 x 4.7 x 0.8 cm. The [redacted] care physician's documentation read, "[redacted] of the right, medial [redacted] -improved evidenced by decreased [redacted] tissue." Recommendations included " [redacted] for [redacted] healing."

On [redacted] the [redacted] measurements were 4 x 3.8 x1 cm, and documentation read, "This [redacted] is in an inflammatory stage and is unable to progress to a healing phase because of the presence of a biofilm. [redacted] progress: Deteriorated ... [redacted] of the right, medial [redacted] -deteriorated due to contamination." Recommendations included: "2.4.20 recommend [redacted] for [redacted] healing; 2.18.20 recommend [redacted] for [redacted] healing."

On [redacted] measurements were 4.5 x 3.5 x 2 cm. Documentation read, " [redacted] of the right, medial

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F 686	Continued From page 7	F 686		

-deteriorated due to patient non-compliance with care, ." Recommendations remained the same as the previous visit.

The Advance registered nurse practitioner (ARNP) notes for resident #7 dated , read, "Noted improvement without , ...will f/u (follow up) with MD." No other documentation could be identified from the ARNP, to indicate follow up with the care MD was done, or that the repeated recommendation for a for healing was addressed.

On at 8:59 AM and at 9:22 AM, the care nurse stated that the resident's to her was a facility acquired and was . She stated that the resident was being followed by the care physician weekly, and daily were done by the care nurse. The care nurse stated that resident #7 was a frequent "wetter" and was seen by the care physician on Tuesday and he recommended a . The care nurse said she must get approval from the resident's primary care physician (PCP) for the insertion of the , and the PCP was made aware of the recommendation on . Review of the " evaluation & management summary" revealed that the care physician made the recommendation for a " for healing" on , , and .

On at 2:25 PM the Director of Nursing (DON) stated the insertion of a was discussed with the PCP. She said the PCP did not want to go the "route" of a , due to the

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resident's history of frequent ..... , ... The DON stated, that the PCP said resident #7 had urogenic ..... , and overflow of , and started the resident on . The PCP had now decided to go with the ... , and orders for the , were placed today .

The resident's current physician orders were reviewed with the DON, and the ... care nurse. An order for could not be identified. Both the DON and the ... care nurse verified this and verified that documentation by the ... care nurse on ... . stated that was ordered. The care nurse stated that she thought the ARNP placed the order in the electronic record, and she did not check to see if the order was placed. The DON stated that the care nurse failed to initiate the physician's order to avoid the ... , ...

On ... at 3:14 PM the ARNP stated that she was aware of the care physician's recommendation for a ... , for resident #7. The ARNP stated she spoke to the care physician and discussed the resident 's history of , , and that she was hesitant to insert a ... , due to this history. She stated that the was not at a point that it was going to be an issue. It was ..... at the time, and she decided to monitor the ... , and assess the ... on her next visit. When asked about documentation, the ARNP stated that she did not document it, it was "just a conversation." She did not feel that the , was warranted at that time and she was trying to be very conservative. The ARNP stated that the was deteriorating, and she decided to go with the , today, . The ARNP stated that the ... , was not discussed on Tuesday,

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(. . . . .). She added that the . . . . . care nurse notified her about the , "either yesterday" . . . . . "or today" . . . . . .

On . . . . . at 3:41 PM, the care physician stated, that generally he documented his recommendation(s) in his notes, but the PCP has the final decision making. The care physician stated that he was aware that the ARNP tried , to try to control the resident's . . . , and was aware of the concern with inserting the . He was made aware of this on Tuesday . . . . . The . . . . . care physician stated that he did not recall speaking directly about the resident with the ARNP on . . . . . , , or . The care physician stated that the resident's was constantly getting wet, and he felt that the , would have helped /contributed to the healing of the resident's .

On at 4:52 PM, an interview was conducted with the Administrator, the DON, the Captiva/Key West unit manager, (UM) and the . . . . care nurse. The resident's . . . . care notes, physician orders, progress notes, and the ARNP notes were reviewed. The care nurse stated that the ARNP gave her a verbal order for . . for resident #7. She said, she usually entered it into the electronic medical record. "I don't know what happened, I could have been distracted, I do not know why I did not put it in." When asked about the facility's process regarding review of the resident's care to ensure adequate and correct implementation of orders, the care nurse said she did not know who followed up. The Captiva/Key West UM stated that she did not go on rounds with the . . . . . care physician, and did not review the

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F 686	Continued From page 10 . . . . care notes. She stated that she depended on the care nurse to keep her informed regarding the resident's . . . . care. The DON stated that the care physician spoke with the ARNP about the resident's on . . . . It was a verbal discussion related to the and it was not documented. The DON stated that the ARNP saw the but there was no documentation provided of the . . . assessment. When asked about communication between the PCP/ARNP, the . . . . physician, and the facility, the facility could not explain how both the ARNP, and the . . . care physician thought the resident was on , when the . . was never ordered. The Administrator stated that the expectation was for the physician/ARNP to document when they saw residents. On at 5:44 PM, the Medical Director (MD) stated that he was aware of the concern with care for resident #7. He was aware that the . . . care physician recommended a , and the ARNP did not was not in favor. The MD stated that . . . would not have had any effect on the , and there were no guidelines for the use of . . . for , . The MD stated that would control episode of , but not the volume. He stated the resident would still need the same care. The MD was informed that both the care physician, and the ARNP believed that the resident was on . . . , when in fact the was never ordered. The MD stated, that he tried to keep communication open, but there were areas for improvement.	F 686		
F 695 SS=D	, , / , Care and Suctioning CFR(s): 483.25(i)	F 695		

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F 695	Continued From page 11 § 483.25(i) , , care, including , care and suctioning. The facility must ensure that a resident who needs , , care, including , care and suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide ( ) at the prescribed rate as per physician's order for 2 of 4 residents reviewed for care of a total sample of 50 residents, (#100, #56). Findings: 1. Review of resident #100's medical record revealed he was admitted to the facility on with diagnoses including , aphasia (loss of ability to understand or express speech), (irregular heartbeat), and ( ). Review of the admission minimum data set (MDS) assessment dated revealed he was rarely/never understood, no behaviors or rejection of care, was totally dependent and required of staff with activities of daily living (ADL), used a wheelchair or walker for mobility, was always of and , had or trouble with breathing when lying flat in bed and received	F 695	1. Resident #100 flow rate was corrected by nursing manager at the time of notification. Resident #56 flow rate was corrected by nursing unit manager at the time of notification. 2. Facility audit conducted by DON/designee on to review all resident's flow rate was delivered at the prescribed rate per physician order. 3. Licensed nursing staff educated by SDC/designee to appropriately verify and ensure residents rate is at the prescribed flow rate. 4. Random weekly audits will be conducted by DON/ designee. The results of these audits will be presented at the monthly QA committee for further review and recommendations for three months and as deemed necessary thereafter.	

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F 695	Continued From page 12	F 695		

Review of resident #100's care plan revised on for Focus read, " dependent related to , status post /extubation while at hospital and with exertion and when lying... Goals: Resident will have no signs or symptoms of poor absorption...Interventions included: resident has humidified via prongs/mask at 3 LPM (liters per minute)."

Review of the resident's physician's orders dated read to administer via NC (.....) at 3 LPM continuously every shift for .

Observations conducted on at 1:50 PM and on at 10:10 AM, noted the resident wearing NC which was connected to the concentrator at bedside which was turned off. On at 12:25 PM, resident #100 was in and had portable tank set at 2 LPM via NC. On at 9:25 AM and 2:20 PM, NC was on resident and connected to the concentrator at beside which was set at 2 LPM.

On at 2:40 PM, ( ) B went into resident #100's room, kneeled down and checked the concentrator. B said, "it is at 2 LPM." B left the room and returned within 2 minutes and stated, "the physician order for is 3 LPM." B stated that nursing staff were responsible to ensure the resident's was set at the prescribed rate.

On at 3:02 PM, the Director of Nursing (DON), Administrator and Licensed Practical Nurse (LPN) A were interviewed. LPN A said she was assigned to resident #100 for the past 3 days

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	105987	A. BUILDING _____ B. WING _____	02/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERS CREEK NURSING AND REHAB CENTER	14155 TOWN LOOP BLVD ORLANDO, FL 32837

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F 695	Continued From page 13 and had checked his during her morning rounds. The DON asked LPN A to demonstrate how she was reading the concentrator setting. LPN A's demonstration revealed that she stood up and looked down at the concentrator flow rate which did not show an accurate reading. LPN A added that she was responsible for connecting resident #100's to the portable when he went to LPN A stated that she did not realize that the resident was only getting 2 LPM when she stood to read the flow rate or from the portable tank on . Review of the facility policy for Administration revised read, "A Licensed Nurse or Care Practitioner performs this procedure...Check physician's order...turn the unit on the desired flow rate, and assess equipment for proper functioning..." 2. Resident #56 was initially admitted to the facility on with diagnoses that included , and On at 10:27 AM, resident #56's ( ) tubing was on the right side of the bed, and the concentrator flow rate was set at 3.5 liters per minute (LPM). On at 4:09 PM, resident #56's was set at 3.5 LPM. On at 10:14 AM and 4:12 PM, resident	F 695		

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F 695	Continued From page 14 #56 was resting in bed with . , . . closed. The , , concentration flow rate remained at 3.5 LPM. A review of the medical record noted a physician order dated that read, " , , via . . . . . specify lpm: 2, every shift for . . ( ).." On at 4:16 PM, Registered Nurse C (RN), said that she had provided care to resident #56, and was replacing the machine tubing. RN C stated that she had just adjusted the . machine to the correct amount of 2 LPN as prescribed by the physician. On . . . . . at 4:46 PM, the Director of Nursing (DON) and , , , B ( ) reviewed resident #56's, physician orders for . and acknowledged that the physician orders were for 2 LPM and not for 3.5 LPM as noted during the last three days.. A review of the residents quarterly Minimum Data Set (MDS) assessment dated . . . . . and annual dated , documented that he was receiving . . . . . , , . Review of resident #56's care plan dated showed interventions to administer . . . , , as ordered and to check rate of . . . flow every shift and as needed.	F		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its-	F 759		

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F 759	Continued From page 15 §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to prevent medication errors for 1 of 6 residents sampled for medication administration observation, (#27). There were 3 errors in 30 opportunities on 1 of 2 units by 1 of the 4 nurses observed, for a medication error rate of 10%. Findings: During a medication administration observation on at 9:30 AM, licensed practical nurse (LPN) A said, she just checked resident #27's , which was . She then proceeded to prepare the resident's scheduled medications. She placed , 10 milligram (mg) tablet, , 50 mg tablet and D3 1000-unit tablet into a pill cup with the resident's other oral medications. Prior to administering the medications, the nurse and surveyor both counted total of 11 pills in the cup. She then proceeded to administer the medications to the resident who was in her room. Review of the medical record for resident #27 revealed her most recent admission to the facility was on . Her current physician orders read: - , tablet 10 mg by (PO) one time a day for (,), hold for (,) below 100 or DBP (diastolic ,) below 60. - , tablet 50 mg PO two times a day for , hold for below 100 or DBP below 60.	F 759	1. Medication variance report for resident #27 was completed on . Resident #27 was evaluated by physician and stated no adverse effects from medication error. LPN A was re-educated on medication administration by SDC at the time of survey. 2. Facility audit conducted by DON/ designee on to review resident's orders were administered as ordered. No other concerns were identified. 3. Licensed nursing staff educated by SDC/ designee on medication administration. 4. Random weekly audits will be conducted by the DON/ designee. The results of these audits will be presented at the monthly QA committee for further review and recommendations for three months and as deemed necessary thereafter.	

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F 759	Continued From page 16 . . . . - . . D3 tablet 1000 units, give 2 tablets po one time a day for (2000 units). On at 2:45 PM a follow up interview was conducted with LPN A. After reading the physician orders regarding resident #27's . . . . , and . . . . , . . , LPN A said, she gave the medications because the was high and she did not follow physician orders regarding parameters to hold for DBP less than 60. She then read the physician order regarding the D3 which indicated that resident #27 was to get total of 2000 units and the nurse said that she though that she had put 2 1000-unit tablets in the pill cup. Surveyor then verified pill count was 11 and if she had given 2 tablets of D3 the pill count should have been 12. On . . . at 2:52 PM, the Director of Nursing (DON) said that LPN A should have done a pill count to eliminate errors and should have held medications (, and ,) when resident #27's DBP was less than 60. Review of the facility Medication Pass Guidelines dated read, "Purpose: To assure the most complete and accurate implementation of physician medication orders and to optimize drug . . . . , , for each resident by providing for administration of drugs in an accurate, safe...Physician Orders- medication are administered in accordance with written orders of the attending physician..."	F 759		

Agency for Health Care Administration

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N 000	INITIAL COMMENTS A re-licensure survey was conducted on [redacted]. Hunters Creek Nursing And Rehabilitation Center had deficiencies found at the time of the survey.	N 000		
N 054 SS=D	59A-4.107(5), FAC Follow Physician Orders All physician orders must be followed as prescribed, and if not followed, the reason must be recorded on the resident's medical record during that shift. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide [redacted] at the prescribed rate as per physician's orders for 2 of 4 residents reviewed for [redacted] care (#100, #56) and failed to administer medications as ordered by the physician for 1 of 6 residents sampled for medication administration, (#27) of a total sample of 50 residents. Findings: 1. Review of resident #100's medical record revealed he was admitted to the facility on [redacted] with diagnoses including [redacted], aphasia (loss of ability to understand or express speech), [redacted] (irregular heartbeat), and [redacted]. Review of the admission minimum data set	N 054	1. Medication variance report for resident #27 was completed on [redacted]. Resident #27 was evaluated by physician and stated no adverse effects from medication error. LPN A was re-educated on medication administration by SDC at the time of survey. Residents #100 and #56's [redacted] flow rate was corrected by nursing unit manager at the time of notification. 2. Facility audit conducted by DON/ designee on [redacted] to review resident's orders to include [redacted] flow rates were administered as ordered. No other concerns were identified. 3. Licensed nursing staff educated by SDC/ designee on medication administration and appropriately verify residents' prescribed [redacted] flow rate. 4. Random weekly audits will be conducted by the DON/ designee. The	

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		/20

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N 054	Continued From page 1 (MDS) assessment dated revealed he was rarely/never understood, no behaviors or rejection of care, was totally dependent and required of staff with activities of daily living (ADL), used a wheelchair or walker for mobility, was always of and , had or trouble with breathing when lying flat in bed and received . Review of resident #100's care plan revised on for , Focus read, " dependent related to , status post /extubation while at hospital and with exertion and when lying... Goals: Resident will have no signs or symptoms of poor absorption...Interventions included: resident has humidified via prongs/mask at 3 LPM (liters per minute)." Review of the resident's physician's orders dated read to administer via NC ( ) at 3 LPM continuously every shift for . Observations conducted on at 1:50 PM and on at 10:10 AM, noted the resident wearing NC which was connected to the concentrator at bedside which was turned off. On at 12:25 PM, resident #100 was in , and had portable tank set at 2 LPM via NC. On at 9:25 AM and 2:20 PM, NC was on resident and connected to the concentrator at beside which was set at 2 LPM. On at 2:40 PM, ( ) B went into resident #100's room, kneeled down and checked the concentrator. B said, "it is at 2 LPM." B left the room and returned	N 054	results of these audits will be presented at the monthly QA committee for further review and recommendations for three months and as deemed necessary thereafter.	

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N 054	Continued From page 2 within 2 minutes and stated, "the physician order for ,, is 3 LPM." B stated that nursing staff were responsible to ensure the resident's ,, was set at the prescribed rate. On at 3:02 PM, the Director of Nursing (DON), Administrator and Licensed Practical Nurse (LPN) A were interviewed. LPN A said she was assigned to resident #100 for the past 3 days and had checked his ,, during her morning rounds. The DON asked LPN A to demonstrate how she was reading the ,, concentrator setting. LPN A's demonstration revealed that she stood up and looked down at the concentrator flow rate which did not show an accurate reading. LPN A added that she was responsible for connecting resident #100's ,, to the portable ,, when he went to ,,. LPN A stated that she did not realize that the resident was only getting 2 LPM when she stood to read the flow rate or from the portable tank on . 2. Resident #56 was initially admitted to the facility on with diagnoses that included , , and , , . On at 10:27 AM, resident #56's ,, ( ) tubing was on the right side of the bed, and the concentrator flow rate was set at 3.5 liters per minute (LPM). On at 4:09 PM, resident #56's ,, was set at 3.5 LPM. On at 10:14 AM and 4:12 PM, resident #56 was resting in bed with , closed. The ,, concentration flow rate remained at 3.5 LPM. A review of the medical record noted a physician	N 054		

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N 054	Continued From page 3 order dated [redacted] that read, "[redacted] via specify LPM: 2, every shift for ([redacted])." On [redacted] at 4:16 PM, Registered Nurse C (RN), said that she had provided care to resident #56, and was replacing the [redacted] machine tubing. RN C stated that she had just adjusted the [redacted] machine to the correct amount of 2 LPN as prescribed by the physician. On [redacted] at 4:46 PM, the Director of Nursing (DON) and [redacted] B ([redacted]) reviewed resident #56's, physician orders for and acknowledged that the physician orders were for 2 LPM and not for 3.5 LPM as noted during the last three days.. A review of the residents quarterly Minimum Data Set (MDS) assessment dated [redacted] and annual dated [redacted], documented that he was receiving [redacted]. Review of resident #56's care plan dated [redacted] showed interventions to administer [redacted] as ordered and to check rate of [redacted] flow every shift and as needed. During a medication administration observation on [redacted] at 9:30 AM, licensed practical nurse (LPN) A said, she just checked resident #27's [redacted] which was [redacted]. She then proceeded to prepare the resident's scheduled medications. She placed [redacted] 10 milligram (mg) tablet, [redacted] 50 mg tablet and [redacted] D3 1000-unit tablet into a pill cup with the resident's other oral medications. Prior to administering the medications, the nurse and surveyor both counted total of 11 pills in the cup. She then proceeded to administer the	N 054		

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N 054	Continued From page 4 medications to the resident who was in her room. Review of the medical record for resident #27 revealed her most recent admission to the facility was on . . . . . Her current physician orders read: . . . . - . . . , . . tablet 10 mg by . . . (PO) one time a day for (,), hold for . . . (. , ... , ...) below 100 or DBP (diastolic . . , . . .) below 60. . . . . . - . . . , ... tablet 50 mg PO two times a day for , hold for . . . below 100 or DBP below 60. - D3 tablet 1000 units, give 2 tablets po one time a day for . . . . . (2000 units). On . . . . . at 2:45 PM a follow up interview was conducted with LPN A. After reading the physician orders regarding resident #27's , and . . , , LPN A said, she gave the medications because the . . . was high and she did not follow physician orders regarding parameters to hold for DBP less than 60. She then read the physician order regarding the . . . D3 which indicated that resident #27 was to get total of 2000 units and the nurse said that she though that she had put 2 1000-unit tablets in the pill cup. Surveyor then verified pill count was 11 and if she had given 2 tablets of . . D3 the pill count should have been 12. On at 2:52 PM, the Director of Nursing (DON) said that LPN A should have done a pill count to eliminate errors and should have held . . medications (. . . , . . . and . . . , .) when resident #27's DBP was less than 60. Review of the facility Medication Pass Guidelines dated . . . . . read, "Purpose: To assure the most complete and accurate implementation of	N 054		

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N 054	Continued From page 5 physician medication orders and to optimize drug , , for each resident by providing for administration of drugs in an accurate, safe...Physician Orders- medication are administered in accordance with written orders of the attending physician..." Class III	N 054		
N 201 SS=D	400.022(1)(l), FS Right to Adequate and Appropriate Health Care The right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to implement interventions to promote the healing of a , for 1 of 1 resident reviewed for , (#7), and failed to provide care in a timely manner for 1 of 3 residents reviewed for activities of daily living (ADL) (#33), of a total sample of 50 residents. Finding 1. Resident #7 was admitted to the facility on and readmitted on . Her diagnoses included 's ,	N 201	1. Physician order regarding , for healing were obtained on for resident #7. ARNP discontinued the order for on . Skin check completed for resident #33 on to observe for skin concerns from delay in receiving , and skin check was clear and intact. 2. Facility audit conducted by DON/ designee on to review care consults within the last 2 weeks and to identify any other residents with concerns for call light response in a timely manner. No further discrepancies were noted.	

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N 201	Continued From page 6 ... to right ..., left ..., left ..., left ..., right ..., right ..., ..., ..., and ..., ... and ... . The resident's current physician orders dated ... read, ... apply to right medial ... everyday shift, cleanse with normal ..., ... dry, apply ..., follow by ... and cover with dry ..., ... is a "product used to help the healing of ... and skin ...It works by helping to break up and remove ... skin and tissue." (WebMD) The quarterly minimum data set (MDS) assessment with assessment reference date ..., revealed that the resident was rarely/never understood, and had total dependence on staff for all activities of daily living. The resident was assessed as being frequently ... of ... and ... . The " ... Rounds" note dated ... read, "Resident was seen by ... care MD (medical doctor) for ... of the right medial ... 3.4 x 2.5 (centimeters)...recommend ..., (...) due to resident constant moisture to promote ... healing." On ... Rounds documentation read, "Resident was seen by ... care MD for ... of the right medial ... 2.5 x 4.7 x 0.8 ...Debridement was performed without any complications ...recommend ... due to resident constant moisture to promote ... healing ..., notified MD orders was given ... for dribbles.." "A ... is a thin, sterile tube inserted into the ... to drain ..." (eMedicineHealth)	N 201	3. Nursing staff educated by SDC/ designee to review and address care consult recommendations and the importance of answering calls in a timely manner and ensure resident's needs are met. 4. Random weekly audits will be conducted by the DON/designee. The results of these audits will be presented at the monthly QA committee for further review and recommendations for three months and deemed necessary thereafter	

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N 201	Continued From page 7 On [illegible] the [illegible] Rounds note read, " Resident was seen by care MD for [illegible] of the right medial [illegible] 4 x 3.8 x1 ... Debridement was performed...skin irritation superficial breakdown due to heavy wetting." The resident's " [illegible] Evaluation & Management Summary" dated read, "She has an [illegible] (due to necrosis) of the right medial for at least 2 days duration." Measurements were, 3.4 cm (centimeter) x 2.5 x not measurable, and the had 25% [illegible]. Debridement was performed to "remove [illegible] tissue and establish margins of viable tissue .... recommend [illegible] for healing.". Documentation indicated, that "The clinical documentation for this consultation was made available to the referring physician ...also made available to the skilled nursing facility at any time for placement in the skilled nursing facility record." A handwritten note documented on the " [illegible] Evaluation & Management Summary" for [illegible] read, "Recommendation noted for placement of ,-will reassess on next visit. D/W (discuss with) ID ( ) but due to recent we will wait on ." On the measurements were 2.5 x 4.7 x 0.8 cm. The [illegible] care physician's documentation read, " , of the right, medial [illegible] -improved evidenced by decreased tissue." Recommendations included " [illegible] for [illegible] healing." On [illegible] the [illegible] measurements were 4 x 3.8 x1 cm, and documentation read, "This is in an inflammatory stage and is unable to progress to a healing phase because of the	N 201		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 201	Continued From page 8 presence of a biofilm. progress: Deteriorated ... of the right, medial -deteriorated due to contamination." Recommendations included: "2.4.20 recommend for healing; 2.18.20 recommend for healing." On measurements were 4.5 x 3.5 x 2 cm. Documentation read, " of the right, medial -deteriorated due to patient non-compliance with care, ." Recommendations remained the same as the previous visit. The Advance registered nurse practitioner (ARNP) notes for resident #7 dated , read, "Noted improvement without ...will f/u (follow up) with MD." No other documentation could be identified from the ARNP, to indicate follow up with the care MD was done, or that the repeated recommendation for a for healing was addressed. On at 8:59 AM and at 9:22 AM, the care nurse stated that the resident's to her was a facility acquired and was She stated that the resident was being followed by the care physician weekly, and daily were done by the care nurse. The care nurse stated that resident #7 was a frequent "wetter" and was seen by the care physician on Tuesday and he recommended a The care nurse said she must get approval from the resident's primary care physician (PCP) for the insertion of the , and the PCP was made aware of the recommendation on . Review of the	N 201		

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N 201	Continued From page 9 " evaluation & management summary" revealed that the care physician made the recommendation for a " , for healing" on , , and . On at 2:25 PM the Director of Nursing (DON) stated the insertion of a , was discussed with the PCP. She said the PCP did not want to go the "route" of a , due to the resident's history of frequent , . The DON stated, that the PCP said resident #7 had urogenic , and overflow of , and started the resident on . The PCP had now decided to go with the , and orders for the , were placed today . The resident's current physician orders were reviewed with the DON, and the care nurse. An order for could not be identified. Both the DON and the care nurse verified this and verified that documentation by the care nurse on stated that was ordered. The care nurse stated that she thought the ARNP placed the order in the electronic record, and she did not check to see if the order was placed. The DON stated that the care nurse failed to initiate the physician's order to avoid the , . On at 3:14 PM the ARNP stated that she was aware of the care physician's recommendation for a , for resident #7. The ARNP stated she spoke to the care physician and discussed the resident 's history of , , , and that she was hesitant to insert a , due to this history. She stated that the was not at a point that it was going to be an issue. It was at the time, and she decided to monitor the , and assess the on her next visit. When asked	N 201		

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N 201	Continued From page 10 about documentation, the ARNP stated that she did not document it, it was "just a conversation." She did not feel that the [redacted], was warranted at that time and she was trying to be very conservative. The ARNP stated that the [redacted] was deteriorating, and she decided to go with the [redacted], today, [redacted]. The ARNP stated that the [redacted], was not discussed on Tuesday, ([redacted]). She added that the [redacted] care nurse notified her about the [redacted], "either yesterday" [redacted] "or today" [redacted]. On [redacted] at 3:41 PM, the [redacted] care physician stated, that generally he documented his recommendation(s) in his notes, but the PCP has the final decision making. The [redacted] care physician stated that he was aware that the ARNP tried [redacted], to try to control the resident's [redacted], and was aware of the concern with inserting the [redacted]. He was made aware of this on Tuesday [redacted]. The [redacted] care physician stated that he did not recall speaking directly about the resident with the ARNP on [redacted], [redacted], or [redacted]. The [redacted] care physician stated that the resident's [redacted] was constantly getting wet, and he felt that the [redacted], would have helped /contributed to the healing of the resident's [redacted]. On [redacted] at 4:52 PM, an interview was conducted with the Administrator, the DON, the Captiva/Key West unit manager, (UM) and the [redacted] care nurse. The resident's [redacted] care notes, physician orders, progress notes, and the ARNP notes were reviewed. The [redacted] care nurse stated that the ARNP gave her a verbal order for [redacted] for resident #7. She said, she usually entered it into the electronic medical record. "I don't know what happened, I could have been distracted, I do not know why I did not	N 201		

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N 201	Continued From page 11 put it in." When asked about the facility's process regarding review of the resident's care to ensure adequate and correct implementation of orders, the care nurse said she did not know who followed up. The Captiva/Key West UM stated that she did not go on rounds with the care physician, and did not review the care notes. She stated that she depended on the care nurse to keep her informed regarding the resident's care. The DON stated that the care physician spoke with the ARNP about the resident's on . It was a verbal discussion related to the and it was not documented. The DON stated that the ARNP saw the but there was no documentation provided of the assessment. When asked about communication between the PCP/ARNP, the physician, and the facility, the facility could not explain how both the ARNP, and the care physician thought the resident was on , when the was never ordered. The Administrator stated that the expectation was for the physician/ARNP to document when they saw residents. On at 5:44 PM, the Medical Director (MD) stated that he was aware of the concern with care for resident #7. He was aware that the care physician recommended a , and the ARNP did not was not in favor. The MD stated that would not have had any effect on the , and there were no guidelines for the use of for . The MD stated that would control episode of , but not the volume. He stated the resident would still need the same care. The MD was informed that both the care physician, and the ARNP believed that the resident was on , when in fact the	N 201		

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N 201	Continued From page 12 was never ordered. The MD stated, that he tried to keep communication open, but there were areas for improvement. 2. Resident #33 was admitted to the facility on with her most recent readmission on . Her diagnoses included , and following unspecified affecting right side and generalized . The quarterly minimum data set (MDS) assessment with assessment reference date revealed the resident's cognition was moderately with a brief interview of mental status ( ) score of . The resident required for bed mobility, , toilet use, and personal hygiene, and was always of and . On at 9:00 AM and at 4:11 PM, resident #33 stated that last night, she was wet and had a movement, and used the call light to call for assistance. She said she put her call light on, waited for half an hour, with no response. She said she then started calling out, "hello, hello." After 10 minutes of calling out, someone came into her room. The resident stated she told staff that she was covered in and needed to be changed. She said the staff member told her to wait a minute as she would get someone to assist. The resident stated that she was not changed until this morning on at about 9:30 AM. at 5:12 PM, the Captiva Unit Manager, (UM) stated that a grievance was placed by the resident this morning regarding the incident. The	N 201		

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N 201	Continued From page 13 UM stated that the facility had cameras that monitored the hallways. She further stated that video footage could be reviewed to see if call lights were on, and when staff responded to the call lights. On . . . . . at 10:22 AM, the Administrator and Director of Nursing (DON) stated that a grievance was started on . . . . . regarding resident #33's concern of not being changed in a timely manner. The Administrator said the resident told the Social Services Director (SSD) that the incident happened sometime after 3 AM on . . . . . . Camera footage for from 3 AM-6:30 AM was viewed with the Administrator and the DON. Footage showed licensed practical nurse (LPN) D entered resident #33's room at 3:17 AM and came out of the room at 3:18 AM. At 4:15 AM, certified nursing assistant (CNA) E went into resident's room. As per the DON, CNA E stated she asked the resident if she wanted to be changed, and the resident stated she was fine. At 4:46 AM, LPN D went into the resident's room. The DON stated, that LPN D told her the resident's call light was on, and the resident asked to be changed. Both the Administrator verified that there was a period of an hour between the time when LPN D responded to the resident's call light, and when the CNA went into the resident's room. The DON said LPN D reported that she turned the resident's call light off, came out of the room, but forgot to tell the CNA. LPN D did not provide . . . . . care to the resident. The DON stated that the 7AM- 3 PM CNA F said the resident was wet when she changed her at approximately 8 AM. On at 11:18 AM, registered nurse (RN) G stated that resident #33 was able to make her needs known, and if the resident told him she	N 201		

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N 201	Continued From page 14 was wet, he would expect the resident to be changed within minutes. On at 5:00 PM the DON stated, that when a resident said they were soiled, someone needed to go in and get care done as soon as possible. On at 5:53 PM, LPN D stated that she worked with resident #33 on on the 11PM-7AM shift. LPN D stated she answered the resident's call light, and the resident told her that she was wet. LPN D said she told the resident she would let the CNA know. LPN D stated resident#33 was very alert and used the call light when she needed something. LPN D stated she saw CNA E go into the resident's room, but she did not see if the CNA changed the resident. LPN D sated, that her expectation was that the resident should be changed immediately. LPN D said she did not change the resident. She reported that the CNA did not inform her that when she approached the resident, the resident stated that she was fine. On at 9:10 AM, the Social Services Director (SSD) stated that a grievance was started on resident #33 on . She said resident #33 stated she was "soaking wet" and had put her call light on around 3 AM on . She added that a staff came in, said she would be right , turned off the call light, but did not come . The resident reported she got changed by another CNA at 9AM. The SSD stated resident #33 was alert, oriented x 2 and able to make her needs known. On at 10:54 AM, the DON and Administrator stated that care was not provided to resident #33 in a timely manner.	N 201		

Agency for Health Care Administration

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N 201	Continued From page 15 A review of the resident's care plan for " Focus" revised on included interventions to "monitor for episodes of and provide care after episode of ; maintain privacy and dignity during care." The facility's policy and procedure "Personal Care Needs Policy" with revision date read, "A patient who is unable to carry out activities of daily living receives the necessary services to maintain personal hygiene." Class III	N 201		