STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105269	A. BUILDING _____ B. WING _____	C 10/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVES CENTER	512 S 11TH ST LAKE WALES, FL 33853

(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 complaint survey for complaint numbers 2021010090, 2021013088 and 2021013221, was conducted on - at Groves Center. The facility was not in compliance with 42 CFR, Part 483, Requirements for Long Term Care Facilities. Complaint numbers 2021010090, 2021013088 and 2021013221 had deficiencies cited at F684.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to provide care and treatment in accordance with professional standards for one (Resident #1) of six sampled residents, as evidenced by an emergency hospital admission related to critical lab values and a diagnosis of Findings included: A record review for Resident #1 revealed admission to the facility on with a diagnoses that included , , , acidosis, hypoosmolality and	F 684	1. Resident # 1 was transferred from facility for evaluation, practitioner & RR notified and did not return to the facility. 2. Current residents' vital signs were audited by Director of Nurses/designee to identify additional residents with potential change in condition with practitioner & RR notified as indicated. A 14 day look was completed Director of Nurses/designee to review unplanned return to hospital events to identify potential delay in identification & reporting of change in condition to practitioner & RR.	

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

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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 684	Continued From page 1 hyponatremia, [redacted], wasting and atrophy, abnormal posture, unsteadiness of [redacted], old [redacted], and [redacted]. Resident #1 was discharged from the facility to the hospital on [redacted]. A review of the Minimum Data Set (MDS) dated [redacted] revealed an admission assessment for Resident #1 had a Brief Interview of Mental Status ([redacted]) score of 11 indicating mild [redacted]. A review of the medical record for Resident #1 revealed orders for [redacted] ([redacted])/Basic [redacted] Profile (BMP) one time only until [redacted] and send to hospital for one time only for critical labs until [redacted]. A review of the progress notes for Resident #1 revealed the following: [redacted] 02:08 Skilled evaluation-[redacted]: amber in color [redacted] 14:57 Skilled evaluation-Vocal complaint of [redacted], generalized, reports that [redacted] occurs multiple times a day 01:24 Skilled evaluation-Vocal complaint of [redacted], generalized, reports that [redacted] occurs multiple times a day [redacted] 14:22 Progress note-Resident labs received as critical medical doctor (MD) notified new orders received to send to hospital. 14:36 Hospital Transfer Evaluation Summary completed. 12:08 Progress note-Resident is currently in the [redacted] with an admitting diagnosis of [redacted] and [redacted].	F 684	3. The DON/Designee educated the nurses on notification of change of condition, documentation of the notification, initiation of orders received and following physicians' orders. 4. The SDC is completing Interviews with staff to conduct audit of understanding of education provided at least 3 times weekly for 1 month. The DON/Designee is completing an audit of residents presenting with change in condition to ensure identified promptly with practitioner & RR notified & interventions implemented. The clinical IDT Team is completing a vital sign review during clinical meeting 5 x weekly for 1 month to ensure practitioners are notified of abnormal vital signs or other signs of change of condition, notifications to the practitioner, initiation of new orders and following physician orders. The DON will present the plan to the Q&A Compliance for 3 months or until substantial compliance has been met.	

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F 684	Continued From page 2 A review of the laboratory results dated ..... for Resident #1 revealed a critically high white ..... count (...) of 25.9 cubic milliliter (k/ul), a critically low hemoglobin ( ) of 7.0 grams per deciliter (g/dl), a critically high ..... ( ) of 111 milligrams per deciliter (mg/dl), and a critically high ..... of 6.2 milliequivalents per liter (meq/l). On at 3:37 p.m. an interview was conducted with the Nursing Home Administrator (NHA) and the Director of Nursing (DON). The NHA stated an allegation of neglect for Resident #1 was received on and an immediate report and investigation into the allegations was begun. The NHA stated record reviews and staff interviews were conducted as part of the investigation and a had been diagnosed on Resident #1 on ..... which was treated with oral ..... ordered by the provider. The NHA stated they had not substantiated the allegation of neglect. The DON indicated an order for labs was entered on which resulted in critical lab values and that is when the resident was sent to the hospital. The DON reviewed the record and was unable to determine why the labs were ordered for the resident. She confirmed nursing notes did not reflect a change of status for the resident on . The DON was the nurse who wrote the order for the laboratory draw and was unable to recall the circumstances that resulted in the order. On ..... at 3:50 p.m. the NHA and the DON returned with a copy of the physician's notes dated ..... and ..... . A review of the physician notes indicated the following: --Notes from the doctor on ..... reflect the	F 684		

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F 684	Continued From page 3	F 684		

resident was having difficulty breathing for days. The notes indicated the patient had been experiencing , in the , increase , production, , greenish yellow in color, current medications are not helping. The general examination indicated work of breathing increased. The assessment was , ( ) exacerbation. The treatment stated "Spoke to nursing staff. Start bronchodilators, , and . Please refer to nursing order sheet. The nursing staff was advised to continue to monitor the patient very closely and if there is change to call me. Spoke to nursing staff regarding plan of care."

--Notes from the doctor on reflect the doctor was called to come and evaluate the patient as patient was noted to be very . The staff was noted that was very cloudy and was complaining of on . There was no in the . There was mild , . The symptoms are progressive. Overall poor history. The general examination indicated ill-appearing. Assessments: Alteration and (,). Treatment: obtain , CMP, UA (,) and C/S (,). "Start the patient empirically. I was instructed nursing staff to continue to monitor closely. Please refer to nursing order. Spoke to nursing staff regarding plan of care."

The DON and NHA stated they had not been aware of the orders in the physician notes. The NHA stated at the time of the investigation she had not discovered the orders that had not been carried out by the nursing staff. The DON confirmed orders given at the time of the physician visit, verbally or written, should have been implemented by the nursing staff. A review

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F 684	Continued From page 4	F 684		

of the medical record for Resident #1 with the DON and NHA revealed no orders written for the physician visit on ..... or ..... .

On ..... at 9:38 a.m. an interview was conducted with the facility Medical Director (MD). The MD verified he was the physician caring for Resident #1. The MD stated he knew Resident #1 very well and had many difficult conversations with the family about the resident and her health problems. He stated he rounds with a nurse, and the nurse takes notes for the orders he gives while rounding and he dictates into his phone. He stated Resident #1 had completed a course of oral ..... for five days on the 19th of ... . The MD stated he had visited Resident #1 on ..... and ..... and his notes reflect the care at the time. The MD stated the expectation would be nursing implements the orders as dictated by him. He did not know why the orders were not implemented for Resident #1.

On ... at 12:21 p.m. an interview was conducted with Staff B, Licensed Practical Nurse (LPN) weekend supervisor. Staff B, LPN reported he remembered Resident #1, and recalled she was sent out to the hospital for critical labs. Staff B, LPN stated if a nurse receives an order, they are to write them out exactly how the doctor gave the order on an order sheet. He stated another nurse verifies the order, then the orders are entered into the computer. He stated the nurse would then print the orders and fax them to the pharmacy or the laboratory. The LPN said lab orders are written into the logbook, located at each nursing station, so they can be tracked and ensure they are completed. Staff B, LPN explained critical labs are called directly to the nurse, and the physician is notified.

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F 684	Continued From page 5	F 684		

Staff B, LPN stated whoever receives the lab results is responsible for entering the information into the progress notes.

A Lab Monitoring Sheet was requested for ; however, the facility was unable to provide. A Lab Monitoring Sheet was produced for showing Resident #1 had a and BMP ordered and drawn.

On at 1:30 p.m. a telephone interview was conducted with Staff C, LPN, previous unit manager. She stated she did not recall the day Resident #1 went out to the hospital and she did not recall caring for that resident. Staff C, LPN stated she was the unit manager then and would not usually have an assignment. She stated if she had cared for the resident she would have documented in the record.

On at 1:45 p.m. an interview was conducted with Staff D, LPN Unit Manager. Staff D, LPN verified she rounds with the physician, and stated the physician will relay all new orders for a resident during rounds. Staff D, LPN indicated the nurse is responsible for writing the orders on an order sheet, placing them into the computer, printing out the order and sending it on to the pharmacy or the laboratory. She stated if the physician was still at the facility when the orders get printed, he would sign them, and if not, he would sign all orders on his next visit. Staff D, LPN stated the expectation is the nurse rounding with the physician follows through with all orders that are given. She indicated this has always been the physician's process and all nurses are aware of it.

On at 2:33 p.m. an interview was

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F 684	Continued From page 6	F 684		

conducted with Staff E, LPN. After review of staffing schedules, he reported he did recall the resident. He stated the physician orders referred to in his notes on and did not ring a bell to him. He confirmed it is the expectation of nursing to write and implement an order given by the physician verbally or in writing. Staff E, LPN stated if the information was relayed to him, he would have written the order, but he did not recall receiving any orders for Resident #1. Staff E, LPN reviewed the record and confirmed no orders had been entered for or . He stated he did not recall any change in status for Resident #1 prior to the critical labs being reported. Staff E, LPN indicated he charts by exception and not every resident gets charted on daily.

Review of the [name of hospital] Emergency Room Record revealed Resident #1 arrived for care on at 15:27 p.m. The Information Source/HPI (history physical information) indicated the resident had a , of and elevated white cell count. The physical exam indicated Resident #1 was stuporous, , severe distress and moves all four extremities to . The Emergency Department course indicated Resident #1 required a central line placement for fluids, medications, and . Resident #1 was admitted to the ( ).

A review of the [name of hospital] Discharge Summary record revealed Resident #1 was discharged on to Hospice.

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N 000	INITIAL COMMENTS A complaint survey for complaint numbers 2021010090, 2021013088 and 2021013221, was conducted on - at Groves Center. Deficiencies were identified at the time of the survey. Complaint numbers 2021010090, 2021013088 and 2021013221 had deficiencies cited at N0201.	N 000		
N 201 SS=G	400.022(1)(l), FS Right to Adequate and Appropriate Health Care (l) 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 record review and interviews, the facility failed to provide care and treatment in accordance with professional standards for one (Resident #1) of six sampled residents, as evidenced by an emergency hospital admission related to critical lab values and a diagnosis of ..., ... Findings included: A record review for Resident #1 revealed admission to the facility on with a diagnoses that included ... ... , , , , acidosis, hypoosmolality and hyponatremia, ... , , ... wasting and atrophy, abnormal posture,	N 201	1. Resident # 1 was transferred from facility for evaluation, practitioner & RR notified and did not return to the facility. 2. Current residents' vital signs were audited by Director of Nurses/designee to identify additional residents with potential change in condition with practitioner & RR notified as indicated. A 14 day look was completed Director of Nurses/designee to review unplanned return to hospital events to identify potential delay in identification & reporting of change in condition to practitioner & RR. 3. The DON/Designee educated the nurses on notification of change of	

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N 201	Continued From page 1 unsteadiness of , , , old , , and . Resident #1 was discharged from the facility to the hospital on . A review of the medical record for Resident #1 revealed orders for , ( )/Basic Profile (BMP) one time only until and send to hospital for one time only for critical labs until . A review of the progress notes for Resident #1 revealed the following: 02:08 Skilled evaluation- : amber in color 14:57 Skilled evaluation-Vocal complaint of , , generalized, reports that , occurs multiple times a day 01:24 Skilled evaluation-Vocal complaint of , , generalized, reports that , occurs multiple times a day 14:22 Progress note-Resident labs received as critical medical doctor (MD) notified new orders received to send to hospital. 14:36 Hospital Transfer Evaluation Summary completed. 12:08 Progress note-Resident is currently in the ( ) with an admitting diagnosis of , and . A review of the Minimum Data Set (MDS) dated revealed an admission assessment for Resident #1 had a Brief Interview of Mental Status ( ) score of 11 indicating mild , . A review of the laboratory results dated for Resident #1 revealed a critically high white count ( ) of 25.9 cubic milliliter (k/ul), a	N 201	condition, documentation of the notification, initiation of orders received and following physicians' orders. 4. The SDC is completing Interviews with staff to conduct audit of understanding of education provided at least 3 times weekly for 1 month. The DON/Designee is completing an audit of residents presenting with change in condition to ensure identified promptly with practitioner & RR notified & interventions implemented. The clinical IDT Team is completing a vital sign review during clinical meeting 5 x weekly for 1 month to ensure practitioners are notified of abnormal vital signs or other signs of change of condition, notifications to the practitioner, initiation of new orders and following physician orders. The DON will present the plan to the Q&A Compliance for 3 months or until substantial compliance has been met.	

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N 201	Continued From page 2 critically low hemoglobin ( ) of 7.0 grams per deciliter (g/dl), a critically high ( ) of 111 milligrams per deciliter (mg/dl), and a critically high , of 6.2 milliequivalents per liter (meq/l). On at 3:37 p.m. an interview was conducted with the Nursing Home Administrator (NHA) and the Director of Nursing (DON). The NHA stated an allegation of neglect for Resident #1 was received on and an immediate report and investigation into the allegations was begun. The NHA stated record reviews and staff interviews were conducted as part of the investigation and a had been diagnosed for Resident #1 on which was treated with oral ordered by the provider. The NHA stated they had not substantiated the allegation of neglect. The DON indicated an order for labs was entered on which resulted in critical lab values and that is when the resident was sent to the hospital. The DON reviewed the record and was unable to determine why the labs were ordered for the resident. She confirmed nursing notes did not reflect a change of status for the resident on . The DON was the nurse who wrote the order for the laboratory draw and was unable to recall the circumstances that resulted in the order. On at 3:50 p.m. the NHA and the DON returned with a copy of the physician's notes dated and . A review of the physician notes indicated the following: --Notes from the doctor on reflect the resident was having difficulty breathing for days. The notes indicated the patient had been experiencing in the , increase production, , greenish yellow	N 201		

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N 201	Continued From page 3 in color, current medications are not helping. The general examination indicated work of breathing increased. The assessment was . . . ( ) exacerbation. The treatment stated "Spoke to nursing staff. Start bronchodilators, , , and . . . . . Please refer to nursing order sheet. The nursing staff was advised to continue to monitor the patient very closely and if there is change to call me. Spoke to nursing staff regarding plan of care." --Notes from the doctor on reflect the doctor was called to come and evaluate the patient as patient was noted to be very . The staff was noted that . . was very cloudy and was complaining of on . . . There was no . . . in the . . . There was mild , . . The symptoms are progressive. Overall poor history. The general examination indicated ill-appearing. Assessments: Alteration . . . . . and . (, ...). Treatment: obtain , CMP, UA (,) and C/S (. . . . .). "Start the patient empirically. I was instructed nursing staff to continue to monitor closely. Please refer to nursing order. Spoke to nursing staff regarding plan of care." The DON and NHA stated they had not been aware of the orders in the physician notes. The NHA stated at the time of the investigation she had not discovered the orders that had not been carried out by the nursing staff. The DON confirmed orders given at the time of the physician visit, verbally or written, should have been implemented by the nursing staff. A review of the medical record for Resident #1 with the DON and NHA revealed no orders written for the physician visit on or . On at 9:38 a.m. an interview was	N 201		

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N 201	Continued From page 4 conducted with the facility Medical Director (MD). The MD verified he was the physician caring for Resident #1. The MD stated he knew Resident #1 very well and had many difficult conversations with the family about the resident and her health problems. He stated he rounds with a nurse, and the nurse takes notes for the orders he gives while rounding and he dictates into his phone. He stated Resident #1 had completed a course of oral for five days on the 19th of . The MD stated he had visited Resident #1 on and and his notes reflect the care at the time. The MD stated the expectation would be nursing implements the orders as dictated by him. He did not know why the orders were not implemented for Resident #1. On at 12:21 p.m. an interview was conducted with Staff B, Licensed Practical Nurse (LPN) weekend supervisor. Staff B, LPN reported he remembered Resident #1, and recalled she was sent out to the hospital for critical labs. Staff B, LPN stated if a nurse receives an order, they are to write them out exactly how the doctor gave the order on an order sheet. He stated another nurse verifies the order, then the orders are entered into the computer. He stated the nurse would then print the orders and fax them to the pharmacy or the laboratory. The LPN said lab orders are written into the logbook, located at each nursing station, so they can be tracked and ensure they are completed. Staff B, LPN explained critical labs are called directly to the nurse, and the physician is notified. Staff B, LPN stated whoever receives the lab results is responsible for entering the information into the progress notes. A Lab Monitoring Sheet was requested for ; however, the facility was unable to	N 201		

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N 201	Continued From page 5 provide. A Lab Monitoring Sheet was produced for showing Resident #1 had a and BMP ordered and drawn. On at 1:30 p.m. a telephone interview was conducted with Staff C, LPN, previous unit manager. She stated she did not recall the day Resident #1 went out to the hospital and she did not recall caring for that resident. Staff C, LPN stated she was the unit manager then and would not usually have an assignment. She stated if she had cared for the resident she would have documented in the record. On at 1:45 p.m. an interview was conducted with Staff D, LPN Unit Manager. Staff D, LPN verified she rounds with the physician, and stated the physician will relay all new orders for a resident during rounds. Staff D, LPN indicated the nurse is responsible for writing the orders on an order sheet, placing them into the computer, printing out the order and sending it on to the pharmacy or the laboratory. She stated if the physician was still at the facility when the orders get printed, he would sign them, and if not, he would sign all orders on his next visit. Staff D, LPN stated the expectation is the nurse rounding with the physician follows through with all orders that are given. She indicated this has always been the physician's process and all nurses are aware of it. On at 2:33 p.m. an interview was conducted with Staff E, LPN. After review of staffing schedules, he reported he did recall the resident. He stated the physician orders referred to in his notes on and did not ring a bell to him. He confirmed it is the expectation of nursing to write and implement an order given by the physician verbally or in writing. Staff E,	N 201		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	65312	A. BUILDING: _____ B. WING _____	C 10/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 201	Continued From page 6 LPN stated if the information was relayed to him, he would have written the order, but he did not recall receiving any orders for Resident #1. Staff E, LPN reviewed the record and confirmed no orders had been entered for . . . . . or . . . . He stated he did not recall any change in status for Resident #1 prior to the critical labs being reported. Staff E, LPN indicated he charts by exception and not every resident gets charted on daily. Review of the [name of hospital] Emergency Room Record revealed Resident #1 arrived for care on at 15:27 p.m. The Information Source/HPI (history physical information) indicated the resident had a , of . . . . and elevated white cell count. The physical exam indicated Resident #1 was stuporous, ... , severe distress and moves all four extremities to , . The Emergency Department course indicated Resident #1 required a central line placement for fluids, medications, and . . . . . Resident #1 was admitted to the ( ). A review of the [name of hospital] Discharge Summary record revealed Resident #1 was discharged on to Hospice. CLASS III	N 201		