

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105320	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/18/2024
NAME OF PROVIDER OR SUPPLIER Dade City Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 37135 Coleman Ave Dade City, FL 33525	

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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34768</p> <p>Based on observation, interview, and record review, the facility failed to obtain wound care orders and perform wound care timely for one (#3) of four sampled residents.</p> <p>Findings included:</p> <p>Resident #3 was admitted on [DATE]. Review of the Admission Record showed diagnoses included but not limited to Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, and diabetes.</p> <p>Review of the physician orders showed:</p> <p>Cleanse with normal saline, pat dry with gauze. Apply Calcium Alginate over ulcers and then apply secondary dressing, kerlix wrap, and secure with tape daily and as needed for left lower extremity venous ulcers with order and start date of 11/13/2024.</p> <p>Cleanse with normal saline, pat dry with gauze. Apply Calcium Alginate over ulcers and then apply secondary dressing, kerlix wrap, and secure with tape daily and as needed for left lower extremity venous ulcers with order and start date of 11/14/2024.</p> <p>Barrier cream with zinc every shift to bilateral buttocks and sacrum for pressure ulcer for 14 days as of 11/13/2024.</p> <p>Review of the November Treatment Administration Record (TAR) showed:</p> <p>Cleanse with normal saline, pat dry with gauze. Apply calcium alginate over ulcers and then apply secondary dressing, border gauze to left lower extremity (LLE) every day and as needed for venous ulcers as of 11/08/2024 to 11/13/2024. Documented as performed on 11/08/24, 11/09/24, 11/11/24, 11/12/24, and 11/13/24.</p> <p>Cleanse with normal saline, pat dry with gauze. Apply Calcium Alginate over ulcers and then apply secondary dressing, kerlix wrap, and secure with tape daily and as needed for left lower extremity venous ulcers with order and start date of 11/14/2024. Documented as performed on 11/14/24, 11/15/24, 11/16/24, 11/17/24, 11/18/24.</p> <p>Barrier cream with zinc every shift to bilateral buttocks and sacrum for pressure ulcer for 14 days as of 11/06/2024. Documented as performed every shift starting 11/06/2024, night shift.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Admit/Readmit Screener dated 11/05/2024 showed Skin Integrity 1. Skin Color: normal for ethnic group. 2. Skin turgor: normal. 3. Does resident have any areas of skin breakdown? Yes. 3a. Describe skin issues and location below: DTI to left buttocks; scab (s) to BLE (Bilateral Lower Extremities).</p> <p>Review of the Skilled Nurses Note showed</p> <p>On 11/09/2024, evening, Section G, SKIN/WOUND: 1. Skin Description: warm/dry. 2. Resident have a surgical wound, No. 3. Other wounds: no wounds present.</p> <p>On 11/11/2024, evening, Section G, SKIN/WOUND: 1. Skin Description: warm/dry. 2. Resident have a surgical wound, No. 3. Other wounds: no wounds present.</p> <p>On 11/13/2024, evening, Section G, SKIN/WOUND: 1. Skin Description: warm/dry. 2. Resident have a surgical wound, No. 3. Other wounds: anterior bilateral lateral lower extremities. Dressing change: 4. Treatment to wound (s) performed on this shift as ordered. 5. Signs and Symptoms of Wound Infection: 2. redness (erythema) 4. purulent drainage. Comments/Notes: Resident continues on ABT for lower leg possible infection. Redness and swelling noted.</p> <p>On 11/16/2024, evening, Section G, SKIN/WOUND: 1. Skin Description: warm/dry. 2. Resident have a surgical wound, No. 3. Other wounds: no wounds present.</p> <p>On 11/17/2024, evening, Section G, SKIN/WOUND: 1. Skin Description: warm/dry. 2. Resident have a surgical wound, No. 3. Other wounds: no wounds present.</p> <p>Review of the Weekly Skin Evaluation dated 11/11/2024 showed: skin intact.</p> <p>Review of the Weekly Skin Evaluation dated 11/12/2024 showed 3. Blanchable redness of buttocks. 4. Skin tear to left lower leg.</p> <p>Review of the Weekly Pressure Wound Evaluation dated 11/07/2024 showed 1a. Date MD / Alternative Notified / Last Update: 11/06/2024. B. Observations / Data: 1. Location: left buttocks. 2a. present on admission. 2b. date acquired was blank. 4. Pressure Ulcer Stage: 3a. II. 5. Visible Tissue: 5b. epithelial tissue present; 5c. Granulation tissue present. 5g. dry. 6. Drainage: none. 7. Odor: no odor. 8. Measurements: 1.5 cm long x 1 cm wide x 0.1 depth. Barrier cream with zinc every shift. Leave open to air.</p> <p>Review of the Weekly Pressure Wound Evaluation dated 11/17/2024 showed Date MD / Alternative Notified / Last Update: 11/13/2024. B. Observations / Data: 1. Location: left buttocks. 2a. present on admission. 2b. date acquired was blank. 4. Pressure Ulcer Stage: 3a. II. 5. Visible Tissue: healed.</p> <p>Review of the Weekly Non-Pressure Wound Evaluation dated 11/07/2024 showed 1a. Date MD / Alternative Notified / Last Update: 11/06/2024. B. Observations / Data: 1. Vascular ulcer. 1a. LLE. 1b. Venous Partial Thickness. 2b. wound noted on 11/05/2024. 5. Visible tissue: 5a. first impression. 5c. granulation. 5f. moist. 6. Drainage: 6a. serosanguinous. 6b. moderate. 7. Odor: no odor. 8. Wound Measurements: 1.0 cm long x 1.0 cm wide x 0.1 cm deep. 9. Peri-wound tissue: 9a. edema, erythema. Treatment: cleanse with normal saline, apply calcium alginate, and cover with border dressing. Wound Progress: Presented on admission.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Weekly Non-Pressure Wound Evaluation dated 11/17/2024 showed 1a. Date MD / Alternative Notified / Last Update: 11/13/2024. B. Observations / Data: 1. Vascular ulcer. 1a. LLE. 1b. Venous Partial Thickness. 2b. wound noted on 11/05/2024. 5. Visible tissue: 5a. improving. 5b. epithelial tissue present. 5f. moist. 6. Drainage: 6a. serous. 6b. moderate. 7. Odor: no odor. 8. Wound Measurements: 0.8 cm long x 0.8 cm wide x 0.1 cm deep. 9. Peri-wound tissue: 9a. erythema. Treatment: cleanse with normal saline, apply calcium alginate, and cover with border dressing. Wound Progress: improving with delayed wound healing.</p> <p>Review of the Baseline Care Plan dated 11/05/2024 showed, I have impaired skin integrity. Location/Stage (if applicable) left buttocks. I will remain free from new areas of skin breakdown through next review date. Approaches included perform skin evaluation upon admission, weekly and as needed. See current physician's orders / TAR for current treatments as ordered by physician was not checked. The care plan lacked pressure ulcer interventions.</p> <p>During an interview on 11/18/2024 at 2:14 p.m., Staff A, Licensed Practical Nurse (LPN) Wound Care nurse stated either she or Staff B, LPN, Wound Care nurse worked every day including weekends and performed the wound care for the residents. Staff A stated when a resident was admitted , the floor nurse was supposed to check the skin on admission and then either Staff A or Staff B came behind them and double checked the skin. Staff A stated when the consultant wound nurse came in, she saw all new admissions whether they had a wound or not. The consultant wound nurse came on Wednesday. Staff A stated, We (Staff A or Staff B) see the new admission resident on the same day of admission before we go home or the next day. Staff A stated if the resident had a wound, they got treatment orders. Staff A stated they usually called the Nurse Practitioner (NP) of the attending physician, or the consultant wound nurse. Staff A stated they usually called the NP of the attending physician first. The consultant wound nurse saw the resident on their next scheduled day. Staff A stated if the resident did not have anything on their skin the consultant wound nurse would not pick them up. If there was something, they would see them weekly. Staff A stated the consultant wound nurse was the only person who measured wounds in the facility. Staff A stated if a resident was admitted on Thursday and the consultant wound nurse did not come in until the following Wednesday, no wound sizes or description were documented. Staff A stated they (Staff A, Staff B, or the admitting nurse) described the wound to the attending physician or consultant wound nurse and received orders based on their description. Staff A stated the E- MAR (Electronic Medication Administration Record) system would not let them document until the next day after the start date of an order. Staff A stated they did not document the day they performed the wound care if it was on the date of the order because the system would not let them enter the documentation. When asked how they documented treatments performed, she stated they don't.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/18/2024 at 3:39 p.m., the DON stated wound care would be performed on admission. If the resident was admitted on the day shift, either Staff A or Staff B would perform the wound care. The floor nurse performing the admission should do a head-to-toe assessment. The floor nurse should document the wounds. The admission nurse had to assess the wounds and should get initial wound care orders to re-dress the wound after the initial assessment. The DON stated if the resident was admitted at night, the nurse would still do a head-to-toe assessment and document the wound. The DON stated they did not do measurements until the consultant wound care nurse saw the resident. The DON stated the nurses could do a wound description, but it was not in their policy to measure the wounds. The DON stated, if a resident was admitted on Thursday and the consultant wound nurse did not come until the following Wednesday, the wound would not be measured for 6 days, but the wound would be cared for. The DON stated the wound care orders should be obtained on admission. The floor nurse performing the admission had to look at the wound and the wound care would start on the day of admission, because they had to take the dressing off to assess the wound. The DON stated the nurses should call the physician at that point for orders. The DON stated a Skilled Nursing Note was needed for any resident having skilled care which included but not limited to therapy, Intravenous (IV) therapy, wound care, wound vac. The DON stated the Skilled Nursing Note was scheduled per shift but had to be done at least daily. The DON stated if the resident had a wound, it should be documented in the Skilled Nursing Notes. The DON stated that if the nurse entered the wound order into the electronic system they could not document on the TAR until the next day. The DON stated if they could not document on the TAR, they could do a nursing note. The DON stated the care plans should be followed related to wound assessments and care. The DON stated Resident #3 should have had Skilled Nursing Notes from 11/05/2024, at least every day. She stated she did not know why the Skilled Nursing Notes were not done. The DON stated the Skilled Nursing Notes should have addressed the wounds in the documentation. She verified the Skilled Nursing Notes lacked wound documentation. The DON reviewed Resident #3's TAR. She stated the TAR showed the ulcer care was not started until 11/08/2024 even though he was admitted on [DATE]. The DON stated she does not know why the care was not started until 11/08/2024 when the order was received on 11/06/2024. The DON reviewed the Weekly Skin Evaluation dated 11/11/2024 and said it should have addressed the wounds. The DON stated not documenting the wound description or care could possibly cause a negative outcome. She stated a change in the wound should be documented in the progress notes or a Skilled Nursing Note. The DON also verified the care plans were not being followed or addressing the wounds.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's policy, Wound Treatment Management, revised 11/23/2022 showed to promote wound healing of various types of wounds, it is the policy of the facility to provide evidence-based treatments in accordance with current standards of practice and physician orders. Policy Explanation and Compliance Guidelines: 1. Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change. 2. In the absence of treatment orders, the licensed nurse will notify physician to obtain treatment orders. This may be the treatment nurse, or the assigned licensed nurse in the absence of the treatment nurse. 3. Dressing changes may be provided outside their frequency parameters in certain situations. 4. Dressings will be applied in accordance with manufacturer recommendations. 5. Treatment decisions will be based on: a. Etiology of the wound: I. Pressure injuries will be differentiated from non-pressure ulcers, such as arterial, venous, diabetic, moisture or incontinence related skin damage. I I. Surgical. III. Incidental. IV. Atypical. B. Characteristics of the wound: I. Pressure injury stage. II. Size - including shape depth and presence of tunneling and / or undermining. III. Volume and characteristics of exudate. IV. Presence of pain. V. Presence of infection or need to address bacterial bioburden. VI. Condition of the tissue in the wound bed. VII. Condition of Peri- wound skin. C. Location the wound. D. Goals and preferences of the of the resident / representative. 7. Treatments will be documented on the Treatment Administration Record or in the electronic health record. 8. The effectiveness of treatments will be monitored through ongoing assessment of the wound. Considerations for needed modifications include: A. Lack of progress towards healing period B. Changes in the characteristics of the wound. C. Changes in the residence goals and preferences, such as at end of life or in accordance with his / her rights.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34768</p> <p>Based on observation, interview, and record review, the facility failed to obtain pressure ulcer wound care orders and provide pressure ulcer wound care in a timely manner for one (#2) of four sampled residents.</p> <p>Findings included:</p> <p>Resident #2 was admitted on [DATE] and discharged on [DATE]. Review of the Admission Record showed the diagnoses included but not limited to benign neoplasm of meninges, diabetes, adult failure to thrive, protein-calorie malnutrition, and encounter for palliative care.</p> <p>Review of the Admit/Readmit Screener dated 10/30/2024, Section SK / Skin Integrity</p> <ol style="list-style-type: none"> 1. Skin Color: normal for ethnic group; 2. Skin turgor: normal; 3. Does resident have any areas of skin breakdown? Yes. <p>3a. Describe skin issues and location below: bruise to both eyes, bruising to BUE (Bilateral Upper Extremities), both heels red, open area to coccyx.</p> <p>Review of the physician orders showed</p> <p>Cleanse stage III sacrum wound with normal saline, apply Medi-honey, apply calcium alginate and then cover with border foam dressing daily and as needed, with an order date of 11/02/2024 to start on 11/03/2024.</p> <p>Cleanse with normal saline, apply single layer of Xeroform and then cover with dry dressing every other day to left elbow (skin tear) as of 11/02/2024 with a start date of 11/04/2024.</p> <p>Cleanse with normal saline, apply single layer of hydrogel and then cover with dry dressing every other day to left elbow (skin tear) as of 11/06/2024 to 11/12/2024.</p> <p>Skin prep to both heel every shift as of 11/02/2024.</p> <p>Licensed skin check every week on Tuesday as of 10/30/2024 to start on 11/05/2024 was discontinued on 11/04/2024.</p> <p>Licensed skin check every week on Wednesday as of 11/04/2024 to 11/06/2024.</p> <p>Review of the October 2024 Treatment Administration Record (TAR) showed no care was provided to the sacrum pressure ulcer, bilateral heels, or skin tear to the left elbow on 10/30/2024 or 10/31/2024. Licensed skin check every week on Tuesday as of 10/30/2024 to 11/05/2024 was not documented as performed.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the November 2024 TAR showed</p> <p>Cleanse stage III sacrum wound with normal saline, apply Medi-honey, apply calcium alginate and then cover with border foam dressing daily and as needed, with an order date of 11/03/2024 and discontinued on 11/12/2024. Documentation showed the sacrum wound care was performed on 11/03/24, 11/04/24, 11/05/24, 11/06/24, 11/07/24, 11/08/24.</p> <p>Cleanse with normal saline, apply single layer of Xeroform / hydrogel and then cover with dry dressing every other day to left elbow (skin tear) as of 11/02/2024 with a start date of 11/04/2024 and discontinue on 11/06/2024. Documentation showed the left elbow care was provided on 11/04/2024, 11/06/2024.</p> <p>Cleanse with normal saline, apply single layer of hydrogel and then cover with dry dressing every other day to left elbow (skin tear) as of 11/06/2024 to 11/12/2024. Documentation showed the left elbow was provided on 11/06/2024.</p> <p>Skin prep to both heel every shift as of 11/02/2024. Documentation showed care was started on evening shift of 11/02/2024.</p> <p>Licensed skin check every week on Wednesday as of 11/04/2024 to 11/06/2024. Documentation showed it was performed on 11/06/2024.</p> <p>Review of the Weekly Pressure Wound Evaluation dated 11/07/2024 showed Date MD/Alternate Notified/ Last updated: 11/06/2024. Date Family/POA (Power of Attorney) notified/ Last update: 11/06/2024.</p> <p>B. Observations / Data: 1. Location: sacrum. 2a. Present on admission. 2b. date acquired was blank. 4. Pressure Ulcer Stage: 3a. III. 5c. granulation tissue present, 5d. slough tissue present. 5f. moist. 6. Drainage: serosanguinous, small amount. 7. Odor: no odor. 8. Measurements: 2 cm (centimeters) long x 2 cm wide x 0.2 depth.</p> <p>Review of the Weekly Pressure Wound Evaluation dated 11/07/2024 showed Date MD/Alternate Notified/ Last updated: 11/06/2024. Date Family/POA (Power of Attorney) notified/ Last update: 11/06/2024. B. Observations / Data: 1. Location: Right heel. 2a. Present on admission. 2b. date acquired was blank. 4. Pressure Ulcer Stage: 3a. STDI (suspected deep tissue injury). 5b. epithelial tissue present, 5g. dry. 7. Odor: no odor. 8. Measurements: 0.8 cm (centimeters) long x 0.8 cm wide x 0.1 depth. Cleanse with normal saline, apply skin prep every shift and leave open to air.</p> <p>Review of the Weekly Pressure Wound Evaluation dated 11/07/2024 showed Date MD Date MD/Alternate Notified / Last updated: 11/06/2024. Date Family/POA (Power of Attorney) notified/ Last update: 11/06/2024. B. Observations / Data: 1. Location: Left heel. 2a. Present on admission. 2b. date acquired was blank. 4. Pressure Ulcer Stage: 3a. STDI (suspected deep tissue injury). 5b. epithelial tissue present, 5g. dry. 7. Odor: no odor. 8. Measurements: 0.8 cm (centimeters) long x 2.0 cm wide x 0.1 depth. Cleanse with normal saline, apply skin prep every shift and leave open to air.</p> <p>Review of the Skilled Nurses Note showed</p> <p>On 10/31/2024, no Skilled Nurse Note documentation</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 11/01/2024, no Skilled Nurse Note documentation</p> <p>On 11/02/2024, evening, Section G, SKIN/WOUND: 1. Skin Description: warm/dry. 3. Other wounds: no wounds present.</p> <p>On 11/03/2024, evening, Section G, SKIN/WOUND: 1. Skin Description: warm/dry. 3. Other wounds: no wounds present.</p> <p>On 11/04/2024, no Skilled Nurse Note documentation</p> <p>On 11/05/2024, evening, Section G, SKIN/WOUND: 1. Skin Description: warm/dry. 3. Other wounds: no wounds present.</p> <p>On 11/06/2024, evening, Section G, SKIN/WOUND: 1. Skin Description: warm/dry. 3. Other wounds: no wounds present.</p> <p>On 11/07/2024, days, Section G, SKIN/WOUND: 1. Skin Description: warm/dry. 3. Other wounds: no wounds present.</p> <p>On 11/07/2024, evening, Section G, SKIN/WOUND: 1. Skin Description: warm/dry. 3. Other wounds: no wounds present.</p> <p>Review of the Weekly Skin Evaluation showed</p> <p>On 10/31/2024, bruises to face and both arms; open areas was blank.</p> <p>On 11/02/2024, skin tear on left elbow, bruises to BUE to arms and hands, right breast, left and right eyes. Open area to sacrum, pressure stage III and pressure stage I to left and right heels.</p> <p>On 11/06/2024 Bruises on Left and right eye, left and right arms, left and right hands. Open areas was blank.</p> <p>Review of the baseline care plan dated 10/30/2024 showed, I have impaired skin integrity. Location / Stage (if applicable) was blank. Goal showed, I will remain free from new areas of skin breakdown through next review date. Approaches included perform skin evaluation upon admission, weekly and as needed. See current physician's orders / TAR for current treatments as ordered by physician was not checked. The care plan lacked pressure ulcer interventions.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/18/2024 at 2:14 p.m., Staff A, LPN looked up Resident #2 and said the resident was admitted on [DATE] with bruises to both eyes, bruising to BUE (Bilateral Upper Extremities), both heels red, and an open area to the coccyx. Staff A stated she performed a Weekly Skin Evaluation on 11/02/2024 and it showed a skin tear on the left elbow, bruises to Bilateral Upper Extremities (BUE), hands, right breast, and both eyes. Resident #2 had an open area to her sacrum, pressure ulcer stage III and pressure ulcers stage I to left and right heels. Staff A verified on 10/31/2024 the Weekly Skin Evaluation was performed by Staff B, LPN and it showed bruising to the face and both arms, and the open area was blank. Staff A, LPN verified the Weekly Skin Evaluation dated 11/06/2024 showed bruises to both eyes, left and right arms, and left and right hands. Open areas were blank, no sacrum wound noted. Staff A stated she expected the floor nurse to do the admission for Resident #2 on 10/30/2024. Staff A stated Staff B should have seen Resident #2 and assessed her on 10/31/2024 and asked for wound care orders. Staff A stated the skin prep for the heels was started on 11/02/2024. Staff A stated she found the heels and put in the skin prep order on 11/02/2024 and started doing it on 11/02/2024. Staff A stated she assessed Resident #2's sacral wound and skin tear on 11/02/2024. Staff A stated Resident #2 had a bandage on the skin tear on her left elbow that was dated 10/30/2024. Staff A stated the orders should have been obtained to start wound care on the 10/31/2024 for Resident #2. Staff A stated, I was off the 30th and 31st. She said her counterpart (Staff B) saw Resident #2 on 10/31/2024. Staff A stated Resident #2's wounds could have gotten worse without care. Staff A reviewed Resident #2's Skilled Nurse Note for 11/07/2024 which showed skin area: warm and dry; no surgical wounds; no other wounds presented. Staff A stated that, Yes, it should be documented there.</p> <p>During an interview on 11/18/2024 at 3:39 p.m., the DON verified Resident #2 was admitted on [DATE] and wound care was not started until 11/03/2024 based on the documentation on the TAR. The DON stated there was not a progress note showing Resident #2 had wound care on 10/30/24, 10/31/24, 11/01/24 or 11/02/24. The DON stated the care plans should be followed related to wound assessments and care. The DON stated Resident #2's admission did not have a description of the sacral wound, the heels nor the skin tear on the elbow. The DON verified the Weekly Skin dated 10/31/2024 did not describe Resident #2's skin completely. She stated she would expect to see wound care orders starting on 10/30/2024 (admission). The DON verified there were no wound care orders written on admission. The DON verified Resident #2's Weekly skin sheets dated 11/06/2024 did not address the coccyx wound and should have. The DON stated the Skilled Nursing notes should have been started on 10/30/2024 for second and third shift. The DON stated there should have been Skilled Nursing notes performed on 10/31/24, 11/01/24, and 11/04/24. The DON reviewed the Skilled Nursing notes documented and verified they did not address the wounds. She stated they showed, no wounds.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105320	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/18/2024
NAME OF PROVIDER OR SUPPLIER Dade City Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 37135 Coleman Ave Dade City, FL 33525	
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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's policy, Pressure Injury Prevention and Management, revised 7/25/2022 showed the facility is committed to the prevention of avoidable pressure ulcers, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcers / injury, prevent infection and the development of additional pressure ulcers / injuries. Policy Explanation and Compliance Guidelines: 1. There are multiple terms used to describe the type of skin damage, including pressure ulcer, pressure injury, pressure sore, decubitus ulcer, and bedsore. For purposes of this policy, pressure injury, as the current standard terminology will be used. 2. The facility shall establish and utilize a systemic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions that's appropriate. 3. Assessment of Pressure Injury Risk A. Licensed nurse will conduct a pressure injury risk assessment, using the Braden Scale for Predicting Pressure Score Risk on residents upon admission / readmission, then quarterly or whenever the residence condition changes significantly. C. Licensed nurses will conduct a full body skin assessment on residents upon admission / readmission, weekly or routinely, and after any newly identified pressure injury. Findings will be documented in the medical record. 4. Interventions for Prevention and to Promote Healing A. After completing a thorough assessment / evaluation, the interdisciplinary team shall develop a relevant care plan that includes measurable goals for prevention and management of pressure injuries and appropriate interventions. B. Interventions will be based on specific factors identified in the risk assessment, skin assessment, and any pressure injury assessment. C. Evidence based interventions for prevention will be implemented for all residents who are assessed at risk or who have a pressure injury present. D. Evidence-based treatments in accordance with current standards of practice will be provided for all residents who have a pressure injury present. I. Pressure injuries will be differentiated from non-pressure injuries such as arterial, venous, diabetic, moisture or incontinence related skin damage. II. Treatment decisions will be based on the characteristics of the wound, including the stage, size, exudate, presence of pain, signs of infection, wound bed, wound edge and surrounding tissue characteristics. E. The goals and preferences of the resident and / or authorized representative will be included in the plan of care F. Interventions will be documented in the care plan and communicated to all relevant staff. 5. Monitoring A. The Director of Nursing or designee will review all relevant documentation regarding skin assessments, pressure injury risk, progression towards healing, and compliance at least weekly, and document a summary of findings in the medical record. B. The attending physician will be notified of: I. The presence of a new pressure injury upon identification. II. The progressions towards healing, or lack of healing, of any pressure injuries weakly. III. Any complications as needed. C. The effectiveness of current preventive and treatment modalities and processes will be discussed in accordance with the QAA Committee Schedule and as needed when actual or potential problems are identified. 6. Modifications of Interventions A. Any changes to the facility's pressure injury prevention and management processes will be communicated to the relevant staff in a timely manner. B. Interventions on a residence plan of care will be modified as needed. Considerations for needed modifications include I. Changes in residence degree of risk for developing pressure injury. II. New onset or recurrent pressure injury development. III. Lack of progression towards healing period IV. Resident non-compliance. V. Changes in the resident's goals and preferences, such as end-of-life or in accordance with his / her rights.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34768</p> <p>Based on observation, interview, and record review, the facility failed to ensure resident documentation was accurate and complete for four (#1, #2, #3, #4) of four sampled residents.</p> <p>Findings included:</p> <p>1. Resident #1 was admitted on [DATE], readmitted on [DATE] and discharged on [DATE].</p> <p>Review of the Admission Record showed diagnoses included but not limited to cellulitis of other sites, Methicillin resistant Staphylococcus Aureus infection, pressure ulcer stage 4 in sacral region, diabetes, hypertension, quadriplegia, contractures of multiple sites, and muscle weakness.</p> <p>Review of the physician orders showed cleanse left/right buttock wound with normal saline and apply collagen and cover with absorbent dressing and secure with tape daily and as needed.</p> <p>Review of the LTC (Long-Term Care) Notes showed</p> <p>On 09/03/2024 section G, SKIN/WOUND: No wounds present.</p> <p>2. Resident #2 was admitted on [DATE] and discharged on [DATE]. Review of the Admission Record showed the diagnoses included but not limited to benign neoplasm of meninges, diabetes, Chronic Obstructive Pulmonary Disease, hypertensive chronic kidney disease stage III, adult failure to thrive, protein-calorie malnutrition, hypotension, and encounter for palliative care.</p> <p>Review of the Admit/Readmit Screener dated 10/30/2024, Section SK / Skin Integrity</p> <p>1. Skin Color: normal for ethnic group;</p> <p>2. Skin turgor: normal;</p> <p>3. Does resident have any areas of skin breakdown? Yes.</p> <p>3 a. Describe skin issues and location below: bruise to both eyes, bruising to BUE (Bilateral Upper Extremities), both heels red, open area to coccyx.</p> <p>Review of the Skilled Nurses Note showed</p> <p>On 10/31/2024, no Skilled Nurse Note documentation</p> <p>On 11/01/2024, no Skilled Nurse Note documentation</p> <p>On 11/02/2024, evening, Section G, SKIN/WOUND: 1. Skin Description: warm/dry. 3. Other wounds: no wounds present.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 11/03/2024, evening, Section G, SKIN/WOUND: 1. Skin Description: warm/dry. 3. Other wounds: no wounds present.</p> <p>On 11/04/2024, no Skilled Nurse Note documentation</p> <p>On 11/05/2024, evening, Section G, SKIN/WOUND: 1. Skin Description: warm/dry. 3. Other wounds: no wounds present.</p> <p>On 11/06/2024, evening, Section G, SKIN/WOUND: 1. Skin Description: warm/dry. 3. Other wounds: no wounds present.</p> <p>On 11/07/2024, days, Section G, SKIN/WOUND: 1. Skin Description: warm/dry. 3. Other wounds: no wounds present.</p> <p>On 11/07/2024, evening, Section G, SKIN/WOUND: 1. Skin Description: warm/dry. 3. Other wounds: no wounds present.</p> <p>Review of the Weekly Skin Evaluation showed</p> <p>On 10/31/2024, bruises to face and both arms; open areas are blank.</p> <p>On 11/02/2024, skin tear on left elbow, bruises to BUE to arms and hands, right breast, left and right eyes. Open area to sacrum, pressure stage III and pressure stage I to left and right heels.</p> <p>On 11/06/2024 Bruises on Left and right eye, left and right arms, left and right hands. Open areas are blank.</p> <p>Review of the baseline care plan dated 10/30/2024 showed, I have impaired skin integrity. Location / Stage (if applicable) was blank. Goal showed, I will remain free from new areas of skin breakdown through next review date. Approaches included perform skin evaluation upon admission, weekly and as needed. See current physician's orders / TAR for current treatments as ordered by physician was not checked. The care plan lacked pressure ulcer interventions.</p> <p>3. Resident #3 was admitted on [DATE]. Review of the Admission Record showed diagnoses included but not limited to Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, and diabetes.</p> <p>Review of the Admit/Readmit Screener dated 11/05/2024 showed SK. Skin Integrity. 1. Skin Color: normal for ethnic group. 2. Skin turgor: normal. 3. Does resident have any areas of skin breakdown? Yes. 3a. Describe skin issues and location below: DTI to left buttocks; scab (s) to BLE (Bilateral Lower Extremities).</p> <p>Review of the Skilled Nurses Note showed</p> <p>On 11/09/2024, evening, Section G, SKIN/WOUND: 1. Skin Description: warm/dry. 2. Resident have a surgical wound, No. 3. Other wounds: no wounds present.</p> <p>On 11/11/2024, evening, Section G, SKIN/WOUND: 1. Skin Description: warm/dry. 2. Resident have a surgical wound, No. 3. Other wounds: no wounds present.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 11/13/2024, evening, Section G, SKIN/WOUND: 1. Skin Description: warm/dry. 2. Resident have a surgical wound, No. 3. Other wounds: anterior bilateral lateral lower extremities. Dressing change: 4. Treatment to wound (s) performed on this shift as ordered. 5. Signs and Symptoms of Wound Infection: 2. redness (erythema) 4. purulent drainage. Comments/Notes: Resident continues on ABT for lower leg possible infection. Redness and swelling noted.</p> <p>On 11/16/2024, evening, Section G, SKIN/WOUND: 1. Skin Description: warm/dry. 2. Resident have a surgical wound, No. 3. Other wounds: no wounds present.</p> <p>On 11/17/2024, evening, Section G, SKIN/WOUND: 1. Skin Description: warm/dry. 2. Resident have a surgical wound, No. 3. Other wounds: no wounds present.</p> <p>Review of the Weekly Skin Evaluation dated 11/11/2024 showed: skin intact.</p> <p>Review of the Weekly Skin Evaluation dated 11/12/2024 showed 3. Blanchable redness of buttocks. 4. Skin tear to left lower leg.</p> <p>Review of the Baseline Care Plan dated 11/05/2024 showed, I have impaired skin integrity. Location/Stage (if applicable) left buttocks. I will remain free from new areas of skin breakdown through next review date. Approaches included perform skin evaluation upon admission, weekly and as needed. See current physician's orders / TAR for current treatments as ordered by physician was not checked. The care plan lacked pressure ulcer interventions.</p> <p>4. Resident #4 was admitted on [DATE]. Review of the Admission Record showed diagnoses included but not limited to severe protein calorie malnutrition, Chronic Obstructive Pulmonary Disease, muscle weakness, rheumatoid arthritis, pulmonary fibrosis, and adult failure to thrive.</p> <p>Review of the LTC Nurses Note showed</p> <p>On 11/05/2024, evening, Section G, SKIN/WOUND: 1. Skin Description: cool / clammy. 2. Resident have a surgical wound, No. 3. Other wounds: no wounds present.</p> <p>On 11/05/2024, evening, Section G, SKIN/WOUND: 1. Skin Description: warm / dry. 2. Resident have a surgical wound, No. 3. Other wounds: no wounds present.</p> <p>On 11/06/2024, day, Section G, SKIN/WOUND: 1. Skin Description: warm/dry. 2. Resident have a surgical wound, No. 3. Other wounds: Has wounds. 3a. sacrum. Dressing Change: 4. Treatment to wound(s) performed on this shift as ordered. 5. Signs and Symptoms of wound infection: none of the above.</p> <p>On 11/06/2024, evening, Section G, SKIN/WOUND: 1. Skin Description: warm/dry. 2. Resident have a surgical wound, No. 3. Other wounds: Has wounds. 3a. sacrum. Dressing Change: 4. Treatment to wound(s) performed on this shift as ordered. 5. Signs and Symptoms of wound infection: none of the above.</p> <p>On 11/07/2024, night, Section G, SKIN/WOUND: 1. Skin Description: warm/dry. 2. Resident have a surgical wound, No. 3. Other wounds: Has wounds. 3a. sacrum. Dressing Change: 4. Treatment to wound(s) performed on this shift as ordered. 5. Signs and Symptoms of wound infection: none of the above.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 11/07/2024, evening, Section G, SKIN/WOUND: 1. Skin Description: warm/dry. 2. Resident have a surgical wound, No. 3. Other wounds: Has wounds. 3a. sacrum. Dressing Change: 4. Treatment to wound(s) performed on this shift as ordered. 5. Signs and Symptoms of wound infection: none of the above.</p> <p>On 11/08/2024, no LTC Nurse Note documentation</p> <p>On 11/09/2024, night, Section G, SKIN/WOUND: 1. Skin Description: warm / dry. 2. Resident have a surgical wound, No. 3. Other wounds: no wounds present.</p> <p>On 11/10/2024, night, Section G, SKIN/WOUND: 1. Skin Description: warm / dry. 2. Resident have a surgical wound, No. 3. Other wounds: no wounds present.</p> <p>Review of the Weekly Skin Evaluations showed</p> <p>On 11/01/2024, open area, wound noted to sacrum, treatment in progress.</p> <p>On 11/05/2024, open area on sacral area.</p> <p>On 11/12/2024, open areas, sacral wound.</p> <p>Review of care plans showed has actual skin breakdown related to unstageable pressure wound to sacrum as of 05/20/2024 and revised 09/09/2024. Interventions included but not limited to complete Weekly Skin Evaluation. Consult wound physician as needed. Wound care as ordered, see current treatment record and physician's orders; monitor effectiveness of / response to treatment as ordered.</p> <p>5. During an interview on 11/18/2024 at 3:39 p.m. The DON reviewed Resident #1's LTC note for 09/03/2024 and stated that the note should have documented the resident had a wound.</p> <p>The DON verified Resident #2 was admitted on [DATE] and wound care was not started until 11/03/2024 based on the documentation on the Treatment Administration Record (TAR). The DON stated there was not a progress note showing Resident #2 had wound care on 10/30/24, 10/31/24, 11/01/24 or 11/02/24. The DON stated Resident #2's admission does not have a description of the sacrum wound, the heels nor the skin tear on the elbow. The DON verified the Weekly Skin Evaluation dated 10/31/2024 did not describe Resident #2's skin completely. She stated she would expect to see wound care orders starting on 10/30/2024 (admission). The DON verified there were no wound care orders written on admission. The DON verified Resident #2's Weekly skin sheets dated 11/06/2024 did not addressed the coccyx wound and should have. The DON stated the Skilled Nursing notes should have been started on 10/30/2024 for second and third shift. The DON stated there should have been Skilled Nursing notes performed on 10/31/24, 11/01/24, and 11/04/24. The DON reviewed the Skilled Nursing notes documented and verified they did not address the wounds. She stated they showed, no wounds.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The DON stated Resident #3's should have had Skilled Nursing Notes from 11/05/2024, at least every day. The DON stated the Skilled Nursing Notes should have addressed the wounds in the documentation. She verified the Skilled Nursing Notes lacked wound documentation. The DON reviewed Resident #3's TAR. She stated the TAR showed the ulcer care was not started until 11/08/2024 even though he was admitted on [DATE]. The DON stated she does not know why the care was not started until 11/08/2024 when the order was received on 11/06/2024. The DON reviewed the Weekly Skin Evaluation dated 11/11/2024 and it should have addressed the wounds. She stated a change in the wound should be documented in the progress notes or a Skilled Nursing Note.</p> <p>The DON reviewed the LTC Nurses Note and stated Resident #4 should have LTC Nurses note on 11/08/2024. She stated she did not know why the LTC nursing note was not done. The DON stated the LTC Nursing Notes should have addressed the wound in the documentation. She verified the LTC notes lacked wound documentation.</p>		