STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105366	A. Building B. Wing	08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vivo Healthcare University	3648 University Blvd S Jacksonville, FL 32216

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38804 Based on observation, interviews, and record review, the facility failed to provide treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, by failing to provide dermatology consults as ordered for one (Resident #4) of four sampled residents. The findings include: On 8/26/2024 at 11:44 am, Resident #4 was observed in her room with several areas of blotches (dark red in color) and scaly skin on the palm of her left hand. A blue plastic glove was covering her right hand. When questioned about her hands, Resident #4 stated, she had an unknown skin condition which affected both her hands. She stated that it was present upon her admission into the facility. She was getting a topical cream for it; however, she hadn't received it in some time. She did not know if it had been discontinued nor did she know the proper diagnosis. Resident #4 explained that the facility nurses had advised her that she needed to see a dermatologist, but she had not seen one yet. The condition was painful, and she wore the glove on her right hand to keep it moisturized. With the resident's permission the glove was removed. Multiple blotches (dark red in color), dry peeling, scaly skin and an open area to the palm of the resident's right hand were observed, along with redness and peeling to several of the fingers on her right hand. (Photographic evidence obtained) Review of Resident #4's medical record revealed an admitted [DATE]. Her diagnoses included encephalopathy; acute respiratory failure with hypoxia; unspecified atrial fibrillation (Afib); other symptoms & signs involving cognitive functions and dependence on supplemental oxygen. Review of the quarterly minimum data set (MDS) assessment dated [DATE] revealed a brief interview for mental status (BIMS) score of 13 out of 15 possible points, indicating intact cognition for Resident #4. Review of the clinical skin assessment revealed Resident #4 was at risk for developing pressure ulcers however; no pressure ulcers were present. Treatments included: applications of ointments/medications other than to feet. Review of the resident's physician orders included: dermatology consult dated 4/15/2024, dermatology consult for reddened dry flaky skin to bilateral palms 8/25/2023, and weekly skin checks. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the most recent care plan revised on 8/15/2024 included: FOCUS At risk for alteration in skin integrity related to decreased mobility, GOAL The resident will have no alteration in skin integrity; INTERVENTION Preventative skin care with turning and positioning, pericare, lotions and other interventions as ordered. FOCUS The resident has potential for pressure ulcer development related to impaired mobility, impaired cognition, GOAL The resident will have intact skin, free of redness, blisters or discoloration b/through review date INTERVENTION Administer medications as ordered. Monitor/document for side effects and effectiveness. Administer treatments as ordered and monitor for effectiveness. Monitor nutritional status. Serve diet as ordered, monitor intake and record. (Photographic evidence obtained) On 8/26/2024 at 4:30 pm, an interview was conducted with Employee A, Registered Nurse (RN) who was familiar with Resident #4. She referred to her as a nice lady. She stated the resident had dermatitis to her hands and that she received an ointment for it. She stated the resident was waiting to see the dermatologist and added it was not getting any better. The resident wore gloves on her hands because they peel. When asked if the resident had seen a dermatologist at the facility, she stated, she was not sure if/when the resident had seen the dermatologist. She explained that a third-party dermatologist comes to the facility on ce a month to see residents and that Resident #4 had been referred to the provider. On 8/26/2024 at 4:49 pm, a follow up interview was conducted with Employee A, RN. She stated that she was not able to locate any dermatology visit notes for Resident #4. She confirmed there were orders for a dermatology consult on 8/25/2023 and also 4/15/2024. When asked about the resident's medication orders, she confirmed that Resident #4 had orders for, Clotrimazole antifungal cream 1%; Tacrolimus 0.1% external ointment and at one point in the past she received Prednisone. Employee A, RN, stated the orders had all ended. On 8/26/2024 at 5:21 pm, Employee A, RN returned with some orders for Resident #4. She confirmed the topical creams were only for a scheduled amount of time and not a standing order. She again confirmed they were not able to locate any of records of a dermatology visit for the resident. During an interview on 8/26/2024 at 5:24 pm with the Director of Nursing (DON), he stated he was not familiar with Resident #4. He confirmed that there was a third-party dermatologist who provided services to residents. He stated the last time the dermatologist was in the facility was on 8/20/2024. He reviewed the orders for Resident #4 and stated she had an order for a dermatology consult on 8/25/2023. He confirmed the resident was not seen on the 8/20/2024 visit nor was he able to locate any documentation that she was ever seen by a dermatologist. He stated the Social Service Director (SSD) typically adds the residents to the list for third party services and he would consult with the SSD regarding Resident #4. On 8/26/2024 at 6:12 pm, an interview was conducted with the Administrator and DON. They stated after consulting with the SSD they were unable to locate any documentation indicating Resident #4 had been seen by the dermatologist as ordered while she resided in the facility.