Printed: 03/27/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105382	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandgate Gardens Rehab and Nursing Center	703 S 29th St Fort Pierce, FL 34947

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 0686

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide appropriate pressure ulcer care and prevent new ulcers from developing.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 22517

Based on clinical and administrative record review and staff interview, the facility failed to ensure that 3 of 3 sampled residents, Residents #1, #2 and #3, reviewed for pressure ulcers, received the necessary treatment and services in a timely manner, consistent with professional standards of practice to promote healing, as evidenced by the staff failed to ensure that a resident who is admitted with a Stage III pressure ulcer received the necessary care and services for 10 days; failed to provide evidence that weekly skin assessments were completed; and failed to provide evidence that the prescribed treatments were performed as prescribed and documented accordingly.

The findings included:

1. Review of the clinical record for Resident # 1 revealed the resident was admitted to the facility on [DATE] with diagnoses that included Metabolic Encephalopathy, Sepsis, and Traumatic Brain Injury. Review of the 11/06/24 second skin assessment documented the resident had a 1 x 0.4 x 0.9 cm open area on the right lower back / flank. Review of the hospital 3008 documented the resident had a Stage III pressure ulcer on the lower back.

Review of the resident's Plan of Care, the facility identified a problem on 11/07/24, The resident is at risk for skin impairment

related to fragile skin, weakness/decreased mobility Interventions include:

Encourage and assist resident to minimize pressure to bony prominences as tolerated.

Encourage and assist resident to turn and reposition as tolerated.

Encourage and assist the resident to wear protective garments as tolerated, as ordered.

Labs/Diagnostics as ordered and notify MD/NP/APRN as indicated.

Monitor/observe skin while providing routine care. Notify nurse for any area of concern as indicated.

Pressure relieving/reducing cushion to chair/mattress as ordered/indicated, as tolerated by resident.

(continued on next page)

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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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Preventative skin treatments as ordered/indicated, as tolerated by resident. Provide incontinence care promptly should any episodes of incontinence occur. Skin checks weekly and as indicated. Report any s/s (signs or symptoms) of skin breakdown to MD/wound team as indicated. The record revealed the wound care physician assessed the resident on 11/11/24 (6 days later) and documented the following: Patient seen for initial wound evaluation.with a PMHx [past medical history] of Arteriosclerotic Heart Disease, COPD [Chronic Obstructive Pulmonary Disease], Seizures, Dementia, and history of TBI [traumatic brain injury] of left side, who presents for evaluation and management of wounds. Patient was recently admitted to the hospital with dehydration, complicated UTI (urinary tract infection), intra-abdominal sepsis due to malfunctioning jejunostomy tube. While admitted during abdominal CT, findings of sclerotic lesion to right pelvis were found. MRI ordered, however, unable to be completed due to patient movement. Patient does have spastic movements during examination today. Patient is alert to self today. She is able to speak a few words when spoken to. She is contracted, lying on right side. Her bilateral hands are contracted as well. She is bed bound. She has multiple areas of non-blanchable redness to bony prominences. Will cover with hydrocolloid. She has multiple areas of excoriation. Will treat with betadine and leave open to air. She has bruising in multiple areas. With bruising to left anterior upper arm; it appears her right arm hits her left arm while she is having tremors. Will protect with hydrocolloid. Her right lower back has a wound where I am unable to see wound bed. Will treat with topical antibiotic at this time to see if any response. After review of chart, I see no history of wound. Areas of note: R [right] great toe 1.5 x 1.5 cm, R mid lat [lateral] foot 1 x 1.2 cm, R medial foot 0.5 x 0.5 cm, L [left] 5th met [metatarsal] 0.8 x 0.5 cm, L mid foot 0.5 x 0.7 cm, L 5th toe 0. 5 x 0.5 cm. Evidence of scarring to sacral, coccyx, and left back from what appears to be previous wounds, L lower back 0.2 x 0.2 cm, R Knee 0.6 x 0.6 cm, R thigh 3 x 1 cm cluster of excoriation, resolving bruising to R arm, L upper arm. L breast redness, applied betadine, left open to air. She has palpable bilateral pedal pulses, no protective sensation. She is incontinent of bladder and bowels. She has PEG [percutaneous endoscopic gastrostomy] tube with excoriations peri tube noted. Significant contributors for increased risk of wound incidence and/or impede healing include but not limited to generalized muscle weakness, impaired mobility, and inevitable effects of aging. Further skin breakdown may be unavoidable due to protein calorie malnourishment and contractures of bilateral lower extremities and hands. Patient is going to rely on staff for frequent repositioning and incontinence changes. She will need low air loss mattress. Applied offloading boots at today's visit. They are to be worn full time. He further identified that the resident had an active problem as Pressure ulcer of right lower back, stage 3. The prescribed wound treatment for Wound # 1 - Clean wound with wound cleanser - apply gentamycin ointment 0.1% into wound bed, wick with 1/4-inch iodoform, cover with border gauze, change daily and PRN (as needed). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of the Treatment Administration Record (TAR) for Resident # 1, despite the resident being admitted with a Stage 3 wound and the physician prescribing wound care on 11/11/24, the resident did not receive wound care until 11/15/24, 10 days after admission to the facility. The TAR documented wound care of Wash area to right lower back with wound cleanser and dry. Apply gentamycin 0.1 into the wound bed, wick with 1/4 iodoform and cover with border gauze every day and as needed, every day shift. Review of the 11/08/24 Admission Minimum Data Set (MDS) Assessment documented the resident had 1 Stage 4 Pressure Ulcer. An interview was conducted on 01/15/24 beginning at 9:45 AM with the Wound Care Nurse (WCN) and the Director of Nursing (DON). The WCN stated that when a resident is admitted with a pressure ulcer, she will contact the wound care physician and inform her what she assessed and obtain verbal orders. She will then place the orders in the electronic medical record. She then stated she contacted the physician regarding Resident # 1 but she is unaware of the orders that were given. She later stated that she did receive orders and reiterated the gentamycin ointment orders from above but failed to input the orders into the electronic medical record. Further review of the medical record revealed that the nursing staff completed the weekly skin assessment on 11/06/24. There were no further weekly skin assessment noted. 2. Record review revealed Resident # 2 was originally admitted to the facility on [DATE] with diagnoses that included Acute Hematogenous Osteomyelitis left ankle and foot. The record documented the resident has multiple wounds on her left lower extremity, distal lateral knee, left heel, mid lateral knee, and left proximal knee. Review of the clinical record revealed the staff completed the wound evaluations for the above identified wounds but failed to complete the weekly skin assessments since 11/28/24. Review of the plan of care for Resident # 2 revealed a 11/09/24 problem, The resident is at risk for skin impairment related to diabetes, fragile skin, neuropathy, obesity, weakness/decreased mobility. The interventions include: Encourage and assist resident to minimize pressure to bony prominences as tolerated. Encourage and assist resident to turn and reposition as tolerated. Encourage and assist resident with nail care as tolerated. Labs/Diagnostics as ordered and notify MD/NP/APRN as indicated. Monitor/observe skin while providing routine care. Notify nurse for any area of concern as indicated. Nutritional supplements/diet as ordered. Consult with dietician as indicated/ordered. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Pressure relieving/reducing cushion to chair/mattress as ordered/indicated, as tolerated by resident. Preventative skin treatments as ordered/indicated, as tolerated by resident. Provide incontinence care promptly should any episodes of incontinence occur. Skin checks weekly and as indicated. Report any s/s of skin breakdown to MD/wound team as indicated. An observation of Resident #2 was conducted on 01/09/25 at 2:15 PM. The observation revealed multiple bruises on the resident's right arm and a blood blister was also noted on this arm. An interview was conducted on 01/09/25 at 2:30 PM with nurse, Staff A caring the resident, a Licensed Practical Nurse. Staff A revealed the completion of the weekly skin assessments depends on where the resident's room is located. The resident is scheduled to be done by the evening staff on Thursday. She also looked in the electronic system and confirmed that the weekly skin assessments have not been completed since 11/28/24. An interview was conducted on 01/09/25 at approximately 3:00 PM with the DON who expressed the resident just had her intravenous line (IV) removed and maybe the bruises on her right arm were due to this. She stated she would evaluate the resident. 3. Review of the clinical record for Resident # 3 revealed the resident was admitted to the facility on [DATE] with diagnoses that included Bilateral Primary Osteoarthritis of hip and an open wound on right hip. Further review of the physician orders revealed that on 11/26/24, the physician prescribed for the resident to receive Triad Hydrophilic Wound Dress External Paste (Wound Dressings), Apply to butt/scrotum topically every day shift for preventative treatment as follows to Cleanse area with Dakins 1/4 and dry. Apply Triad everyday/prn (as needed) after incontinent episodes. Review of documentation and the TAR revealed the nurses failed to place their initials in the appropriate boxes to indicate they completed the treatment on 12/06/24, 12/11/24, 12/15/24, 12/20/24, 12/25/24, and 01/10/25. Additionally, the physician prescribed on 11/27/24 for wound care, right lateral thigh, Wash with Wound cleanser and dry. Apply Iodosorb to wound bed, lightly place calcium alginate wick and cover with border gauze every Monday Wednesday and Friday and prn (as needed) every day shift. Review of documentation and the TAR revealed the nurses failed to place their initials in the appropriate boxes to indicate they completed the treatment on 12/06/24, 12/11/24, 12/20/24, 12/25/24 and 01/10/25. An interview was conducted on 01/15/24 beginning at 9:45 AM with the Wound Care Nurse and the Director of Nursing. The WCN stated she knows her residents and she would just do the treatment. She further confirmed she would sometimes fail to go to the electronic medical record and check the orders before performing the treatment.