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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105472 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/16/2024 |
| NAME OF PROVIDER OR SUPPLIER Village on the Isle | | STREET ADDRESS, CITY, STATE, ZIP CODE 910 Tamiami Trail South Venice, FL 34285 | |

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

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155</p> <p>Based on record review and staff interviews, the facility failed to obtain daily weights as ordered for 1 (Resident #4) of 1 resident reviewed with congestive heart failure, which may cause the resident to retain fluids.</p> <p>The findings included:</p> <p>The facility policy Physician Services with a date of June 13, 2018, documented, . All physician orders will be followed as prescribed and if not followed, the reason shall be recorded on the resident's medical record during that shift .</p> <p>Review of the clinical record revealed Resident #4 had a readmitted [DATE]. Diagnoses included dementia, chronic kidney disease, and congestive heart failure(CHF).</p> <p>On 4/29/24 at 8:58 a.m., the Advanced Practice Registered Nurse (APRN) documented in a progress note Resident #4 had non-pitting edema (swelling that feels firm to touch) to the right lower leg, right ankle, and left ankle. The APRN noted the edema was dependent upon positioning.</p> <p>On 4/29/24 at 11:02 a.m., the physician issued an order for daily weight to be completed before breakfast and confirmed by the nurse for a diagnosis of heart failure. The order specified to notify the physician if Resident #4 gained more than two pounds (lbs.) in 24 hours or greater than five lbs. in a week.</p> <p>On 4/29/24 at 2:04 p.m., the Registered Dietitian documented a readmission assessment noting Resident #4 had 2+ pitting edema (swelling that leaves an indentation when pressed) to both lower extremities, and daily weights were being monitored.</p> <p>Review of the weight record showed the following recorded weights:</p> <p>4/29/2024: 139.2 lbs.</p> <p>5/1/2024: 134.9 lbs.</p> <p>5/5/2024: 136.0 lbs.</p> <p>5/6/2024: 135.8 lbs.</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>5/9/2024: 130.6 lbs.</p> <p>5/11/2024: 130.9 lbs.</p> <p>5/13/24: 140.1 lbs.</p> <p>There were no weights documented on 4/30/24 and no documentation Resident #4 refused to be weighed.</p> <p>On 5/2/24 at 3:03 p.m., the nurse documented the resident refused to get out of bed to be weighed.</p> <p>On 5/3/24 at 6:52 a.m., the nurse progress note documented resident does not want to get up, get dressed now, will have day Certified Nursing Assistant (CNA) obtain weight before breakfast.</p> <p>On 5/4/24 at 6:44 a.m., the nurse documented day CNA will obtain weight when resident is ready to get up and dressed.</p> <p>On 5/7/24 at 7:06 a.m., the nurse documented day CNA to obtain the weight before breakfast.</p> <p>On 5/8/24 at 6:09 a.m., the nurse documented day CNA will obtain weight when dressed and awake.</p> <p>On 5/10/24 there was no documentation of why the weight was not obtained as ordered.</p> <p>On 5/12/24 at 5:52 a.m., the nurse documented day CNA will obtain weight when resident is dressed and ready to wake up.</p> <p>On 5/14/24 at 1:19 p.m., in an interview Licensed Practical Nurse (LPN) Staff A said the resident refuses to be weighed at times. The LPN said, today, she refused, and I documented it in the progress note. LPN Staff A was not able to locate the missing weights in the electronic clinical record and said the weights would not be written anywhere else. Staff A said, I go with the CNA to weigh the resident.</p> <p>On 5/14/24 at 1:50 p.m., in an interview the Director of Nursing (DON) said the Certified Dietary Manager or the Unit Manager had the missing weights on a paper and had not put them into the electronic record yet. The DON said, I understand what you are saying when asked how the nurses would know and notify the physician if the resident had a weight gain of two lbs. in 24 hours or five lbs. in one week if the weights were not documented.</p> <p>On 5/15/24 at 8:35 a.m., in an interview the DON, said she was not able to locate Resident #4's missing weights but was told the resident refused to be weighed. The DON verified there was no documentation Resident #4 consistently refused to be weighed and no documentation the physician was notified of the missing weights.</p> <p>On 5/16/24 at 9:13 a.m., in an interview the APRN said she was not aware the weights were not consistently obtained as ordered. The APRN said the fact that the facility did not follow the physician order was a concern.</p> | | |

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| <p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155</p> <p>Based on observation, staff interviews, record review, and review of facility policy and procedure, the facility failed to ensure 1 (Residents #3) of 3 residents reviewed with grab bars was assessed for alternative interventions prior to the use of grab bars. The facility failed to assess for danger of entrapment prior to use of the use of the grab bars and failed to conduct periodic maintenance of the grab bars to ensure they remained safe for resident's use. The facility had a total of 30 residents using grab bars.</p> <p>The findings included:</p> <p>The facility policy bedrails dated 6/11/18 documented, The facility shall provide adequate management of bedrails to ensure that residents attain or maintain the highest practicable physical, mental and psychosocial well-being.</p> <p>Procedure:</p> <p>1) The facility will attempt to use appropriate alternatives prior to installing a side or bed rail.</p> <p>2) If a bed or side rail is used, the facility will ensure correct installation, use and maintenance of bedrails, including:</p> <p>Assess the resident for risk of entrapment from bedrails prior to installation . Follow the manufacturers recommendations and specifications for installing and maintaining the bedrails.</p> <p>The manufacturers User-Service Manual for the bedrails specified, Warning, risk of serious injury or death. Do not use this assist device if any openings within the assist body will allow a resident to get his/her head or neck lodged within these openings . Proper combinations of bed, mattress, head/foot panels and assist devices are needed to minimize the risk of entrapment. Entrapment zones involve the relationship of components often directly assembled by the healthcare facility rather than the manufacturer. Therefore, compliance is the responsibility of the facility . Long term care facilities have particular exposure since serious entrapment events, typically involve frail, elderly or dementia patients.</p> <p>On 5/13/24 at 12:41 p.m., Resident #3 was observed in bed on a scoop (raised borders) mattress, over the bed trapeze (helps to move in bed), and grab bars on both sides of the bed in a raised position.</p> <p>Review of the clinical record revealed Resident #3 had a readmitted [DATE], with diagnoses including depression, anxiety, morbid obesity, cerebral infarction, macular degeneration, and weakness.</p> <p>A physician order dated 1/29/24 specified assist rail to left and right side of the bed to assist with bed mobility, and transfers, per resident request.</p> <p>(continued on next page)</p> |

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| <p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>A side rail consent form was signed by the resident on 1/1/29/24.</p> <p>The quarterly side rail assessment screen dated 2/16/24 documented side rails were indicated to enable positional changes and improve bed mobility. There were no documentation of alternatives interventions attempted before the grab bars were applied.</p> <p>On 5/14/24 at 2:35 p.m., in an interview the Director of Rehabilitation (DOR) said the therapy department screens the residents upon admission. If the resident is unable to turn in bed or sit up then they try the grab bar and if the resident is able to use it to increase function, then it is recommended. The DOR said there was no alternative intervention to use other than a trapeze, the facility did not have enough of them, and not all residents were able to use the trapeze due to lack of muscle strength. The DOR said therapy staff did not document the alternatives attempted and why they were not appropriate for the resident. The DOR said, That is a nursing thing.</p> <p>Review of the Occupational Therapy and Physical Therapy evaluation and plan of treatment for Resident #3 dated 9/10/23 did not document the use of a trapeze, scoop mattress or grab bars. The Director said he had no documentation alternate interventions were attempted prior to recommending the grab bars.</p> <p>On 5/14/24 at 3:07 p.m., in an interview the Director of Nursing (DON) said she was aware the therapy documentation did not include screening for the use of the grab bars.</p> <p>On 5/15/24 at 8:47 a.m., the DON said the beds do not have the grab bars on them until therapy evaluates the resident and if they feel the resident will benefit from them, that is when we get an order and have them placed on the beds. The DON said Resident #3 was admitted several years ago and had a recent admission to the hospital. She said, we just left the trapeze and everything on the bed because we knew she would be back, we did not remove it.</p> <p>On 5/15/24 at 2:54 p.m., in an interview the Maintenance Director said, Every month I do bed inspections. I check the gaps between the mattress and headboard and the footboard. I check the wires and the locks.</p> <p>The Maintenance Director said there is a lock that hold the mattress from moving up or down, but it can move sideways. When therapy asks him to put the grab bars on, that is when he puts them on the bed. He removes them when a resident leaves.</p> <p>The Maintenance Director said, Like I said, I check the welds, wires the whole bed, I move it up and down to make sure it is functioning. I do not check the entrapment zones for the grab bars. I do not check for entrapment with the grab bars and I don't do routine maintenance on them.</p> | | |