STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105513	A. Building B. Wing	06/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Claridge House Nursing and Rehabilitation Center	13900 NE 3rd Court North Miami, FL 33161

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48906 Based on record review and interviews, the facility failed to ensure medical records were complete and accurate with all information related to the care and services for one resident (Resident#1) out of nine sampled residents in accordance with accepted professional standard of practices as evidenced by no follow up documentation following an order for a wound care consult for Resident # 1. There were 210 residents residing in the facility at time of this complaint survey The findings included: Record review of demographic sheet for Resident#1 revealed admitted s of 1/31/20, 7/14/23 and 9/12/20, and discharge date s of 7/26/23, 9/1/23, and 9/25/23) with diagnosis that included Pressure Ulcer of Sacral region, Unstageable. Record review of the five- day Medicare Minimum Data Set (MDS) dated [DATE], Section C for cognitive status revealed a Brief Interview for Mental Status score of Three on a scale of zero to 15, indicated severe cognitive impairment. Section GG for functional status revealed the resident is dependent for toileting and transfer, and Section M for skin revealed Resident #1 had one or more unhealed pressure ulcers/injuries. Record review of the Care Plan initiated on 08/04/2023; Revised on 09/25/2023 revealed problem: Resident#1 has a pressure injury to sacral stage 4 on readmission 8/04/23. Interventions included: Consult/make referral for screen by wound nurse as needed. Record review of nursing note dated 6/17/23 written at 10:29 AM revealed a nurse identified Resident #1 had a re-opened area to sacral with pinkish skin, no drainage noted. MD (Medical Doctor) aware, with house cream applied until seen by wound nurse. Record review of physician orders revealed an order dated 6/17/24 for a wound care consult for Resident #1. No other documentation regarding re-opening of wound found in the resident's medical record. Record review of nursing note dated 6/26/23 written at 2:39 PM revealed a call received from nurse at dialysis center that Resident #1 will be sent to a nearby hospital. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of nursing note dated 7/14/23 written at 8:56 AM revealed Resident #1 was readmitted to facility with a sacral wound. On 6/19/24 at 2:13 PM, Staff A Licensed Practical Nurse (LPN) stated: If a wound is identified any time after admission a wound care consult is ordered, and the wound care nurse evaluates the resident and get treatments orders from physician. [Resident #1 was initially admitted on [DATE] with no wounds. There was a wound identified on 6/17/24 and a wound care consult was ordered on that date. There is no documentation that I evaluated the resident after 6/17/24 when the nurse recorded that the wound was reopened. I don't remember why. On 6/19/24 at 2:45 PM. The Director of Nursing (DON) approached surveyor with Staff A, LPN and revealed, Resident #1 was evaluated by Staff A, LPN after an order for wound care consult was received, however there is no documentation due to no opening of the skin observed by Staff A, LPN at the time of evaluation, despite what was written by the nurse.