STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105813	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Ridge Nursing Center	730 College Street Jacksonville, FL 32204

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38804 Based on observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at S483.10(c)(2) and S483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 of 23 residents sampled, Resident #32. The findings include: During a tour of the facility on 5/13/2024 at 12:40 pm Resident #32 was observed resting in his bed. The resident had the covers pulled up to his neck, fully covering his entire body from the neck down. The resident was greeted by members of the survey team. He attempted to respond verbally to the greeting; however, his speech was mumbled and unintelligible. While mumbling the resident pulled the covers down revealing his upper body. He lifted his left forearm. The survey team observed a white medical bandage with 5/8 and initials written in red ink near the center of the bandage. The resident was asked if the area caused him any pain. Again, he responded with unintelligible mumbles. (photographic evidence obtained) Review of the electronic medical record for Resident #32 revealed he was admitted into the facility on [DATE]. His most recent readmission was on 2/7/2024. His diagnoses included metabolic encephalopathy; major depressive disorder; esophagitis unspecified with bleeding; aphasia; peripheral vascular disease (PVD); unspecified dementia; anorexia; and cerebral infarction pneumonitis due to inhalation of food and vomit. Record review revealed physician orders which included treatment to skin tear left outer elbow, cleanse with wound cleanser and pat dry. Apply Xeroform, cover with dry dressing daily and as needed, if loose or soiled every day shift every other day for skin tear tx. Order date 5/8/2024. Per review of the treatment administration record (TAR) the treatment was completed on 5/10/2024, 5/12/2024, and 5/14/2024. Record review revealed a Care Plan with a review start date of 5/9/24 and a target completion date of 5/16/2024. Focuses included: I have a (actual/potential) impairment to my skin integrity r/t PVD, diabetes. Goal: I will be free of skin impairments through the review date. Interventions on 5/8/2024 and 5/13/2024 included: treatment as ordered and follow facility protocols for treatment of skin impairments. (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: 105813	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER Park Ridge Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 730 College Street Jacksonville, FL 32204	

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 5/15/2024 at 2:40 pm with Employee C, a licensed practical nurse (LPN). She stated she had been employed in the facility approximately 30 days. She stated she was familiar with Resident #32. She confirmed that the resident had a skin tear to his left forearm as well as a skin prep to his left heel. She stated she could not always make out what the resident was saying. She stated his vitals are taken everyday and he is checked to ensure he has been changed [incontinence care]. She was asked who was responsible for changing the resident's bandages. She replied that it was the responsibility of the nurses. She stated that she had done it before. She was asked to access the TAR to confirm when the bandage had been changed and the nurse who changed it. She replied that she was not familiar with how to do that. An interview was conducted on 5/15/2024 at 3:09 pm with Employee D, LPN. She stated she was familiar with Resident #32. She stated she changed the dressing on his left forearm on 5/14/2024 adding that it should be changed every other day. She stated there was confusion in the way the order was written. It was not to be changed daily. She stated she would update the order. She was asked if there were any concerns with the skin tear and/or bandage when she changed the dressing on 5/14/2024. She stated she didn't notice any problems when she changed the dressing adding that it was intact. She was asked to provide the dates the bandage had been changed prior to her changing it on 5/14/2024. She stated it should have been changed on 5/10/2024 and 5/12/2024. She confirmed if the bandage was changed as ordered it would have have reflected 5/12/2024 when she changed it on 5/14/2024. She advised the survey team that she didn't see any problems with that on 5/14/2024 when she changed the bandage. She confirmed the date of the order was 5/8/2024. In the presence of the survey team she reviewed the TAR. She confirmed that she signed off on the TAR indicating she changed the bandage on 5/14/2024. She stated Employee C signed off on the TAR on 5/10/2024 and 5/12/2024 indicating that she changed the bandage as ordered. An interview was conducted on 5/15/2024 at 3:25 pm with the Director of Nursing. She reviewed the TAR for Resident #32 with the surveyor. She confirmed the check in the box under the date indicated the treatment was done. She confirmed the treatment order was for every other day. She stated the bandage should have been changed 5/10/2024, 5/12/2024, and 5/14/2024. She was shown the picture of the dressing taken on 5/13/2024 at 12:40 pm reflecting 5/8/2024. She stated there should not have been a check mark under 5/10/2024 nor 5/12/2024 indicating the treatment was done. She stated the nurse should have documented why the treatment was not done. Record Review revealed the facility developed a policy for Wound Treatment Management. The policy was reviewed/revised on 1/4/2024. Per 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. 45673

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45673 Based on observations, staff interview, record review, and facility policy review , the facility failed to ensure that the resident, who required oxygen therapy was provided such care consistent with professional standards of practice, the comprehensive care plan, and physician's orders for one (Resident #18) of 23 residents sampled. The findings include: Observation on 05/13/24 at 12:19 PM revealed Resident #18's oxygen concentrator was set at 2 liters per minute (LPM), but the oxygen tubing was not placed in resident's nostrils. The tubing was observed uncovered and hanging close to floor. (photographic evidence obtained) Observation on 05/15/24 at 1:57 PM revealed Resident #18 being transferred back to bed via Hoyer lift with 2 staff assisting. Employee A, CNA, made resident comfortable in bed and then left the room. The resident's oxygen nasal cannula was not placed in her nostrils at this encounter. The tubing was in a bag hanging on the concentrator. (photographic evidence obtained) The surveyor waited in the room to observe the resident and to observe if the nurse would arrive to place nasal cannula. Employee A returned to the room and placed the resident's call light in reach. She left the room again. The resident's nasal cannula was not placed in her nostrils at this encounter. Record review revealed Resident #18, date of birth 05/11/1935, was admitted to the facility on [DATE] with diagnoses of senile degeneration of the brain, contracture of muscle, dementia in other diseases classified elsewhere, moderate with anxiety, anorexia, arteriosclerotic heart disease, cough, abnormal posture, and allergy. A review of the Quarterly MDS dated [DATE] revealed Resident #18 had a Brief Interview for Mental Status (BIMS) of 11/15 required eating supervision or touching assistance. She required staff assistance with transfers and bed mobility, and required substantial/maximal staff assistance with toileting. She had a condition/chronic disease that may result in a life expectancy of less than 6 months and was also receiving oxygen therapy and hospice services during the lookback. A review of Resident #18's orders revealed she had orders including Oxygen 2-4L via nasal cannula continuously every shift. A review of the Care Plan revealed there was no care plan focus for oxygen therapy. A review of Community Hospice Notes revealed pertinent information that pertained to respiratory status and oxygen use of 2-3Lpm via nasal cannula with oxygen saturations ranging from 92-97 %. No concerns identified. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/15/24 at 2:16 PM an interview was conducted with Employee B, CNA, who had assisted Employee A transfer Resident #18 to bed. When asked what her role was in managing a resident's oxygen she stated, We don't manage the oxygen because it's a medicine. When asked what she would do if resident was using oxygen and had a change of condition she stated, I would get the nurse. When asked what the CNA's role is concerning residents who use oxygen she stated, If the tubing falls out of the nose, we can put it back in, or we go and get the nurse if something else needs to be done to it, but that's about it. Review of the policy, Oxygen Administration, Date Reviewed/Revised 01/04/24, revealed the following: Policy: Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences. 1. Oxygen is administered under orders of a physician, except in the case of an emergency. 48947

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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	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** 38804 Based on observation, interview, and record review the facility failed to ensure medical records were maintained on each resident that are complete, accurately documented, readily accessible and systematically organized for one of 23 residents sampled, Resident #32. The findings include: During a tour of the facility on 5/13/2024 at 12:40 pm Resident #32 was observed resting in his bed. The resident had the covers pulled up to his neck, fully covering his entire body from the neck down. The resident was greeted by members of the survey team. He attempted to respond verbally to the greeting; however, his speech was mumbled and unintelligible. While mumbling the resident pulled the covers down revealing his upper body. He lifted his left forearm. The survey team observed a white medical bandage with 5/8 and initials written in red ink near the center of the bandage. The resident was asked if the area caused him any pain. Again, he responded with unintelligible mumbles. (photographic evidence obtained) Review of the electronic medical record for Resident #32 revealed he was admitted into the facility on [DATE]. His most recent readmission was on 2/7/2024. His diagnoses included metabolic encephalopathy; major depressive disorder; esophagitis unspecified with bleeding; aphasia; peripheral vascular disease (PVD); unspecified dementia; anorexia; and cerebral infarction pneumonitis due to inhalation of food and vomit. Record review revealed physician orders which included treatment to skin tear left outer elbow, cleanse with wound cleanser and pat dry. Apply Xeroform, cover with dry dressing daily and as needed, if loose or soiled every day shift every other day for skin tear tx. Order date 5/8/2024. Per review of the treatment administration record (TAR) the treatment was completed on 5/10/2024, 5/12/2024, and 5/14/2024. Record review revealed a Care Plan with a review start date of 5/9/24 and a target completion date of 5/16/2024. Focuses included: I have a (actual/potential) impairment to my skin integrity r/t PVD, diabetes. Goal: I will be free of skin impairments through the review date. Interventions on 5/8/2024 and 5/13/2024 included: treatment as ordered and follow facility protocols for treatment of skin impairments. An interview was conducted on 5/15/2024 at 2:40 pm with Employee C, a licensed practical nurse (LPN). She stated she had been employed in the facility approximately 30 days. She stated she was familiar with Resident #32. She confirmed that the resident had a skin tear to his left forearm as well as a skin prep to his left heel. She stated she could not always make out what the resident was saying. She stated his vitals are taken everyday and he is checked to ensure he has been changed [incontinence care]. She was asked who was responsible for changing the resident's bandages. She replied that it was the responsibility of the nurses. She stated that she had done it before. She was asked to access the TAR to confirm when the bandage had been changed and the nurse who changed it. She replied that she was not familiar with how to do that. (continued on next page)

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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	An interview was conducted on 5/15/2024 at 3:09 pm with Employee D, LPN. She stated she was familiar with Resident #32. She stated she changed the dressing on his left forearm on 5/14/2024 adding that it should be changed every other day. She stated there was confusion in the way the order was written. It was not to be changed daily. She stated she would update the order. She was asked if there were any concerns with the skin tear and/or bandage when she changed the dressing on 5/14/2024. She stated she didn't notice any problems when she changed the dressing adding that it was intact. She was asked to provide the dates the bandage had been changed prior to her changing it on 5/14/2024. She stated it should have been changed on 5/10/2024 and 5/12/2024. She confirmed if the bandage was changed as ordered it would have have reflected 5/12/2024 when she changed it on 5/14/2024. She advised the survey team that she didn't see any problems with that on 5/14/2024 when she changed the bandage. She confirmed the date of the order was 5/8/2024. In the presence of the survey team she reviewed the TAR. She confirmed that she signed off on the TAR indicating she changed the bandage on 5/14/2024. She stated Employee C signed off on the TAR on 5/10/2024 and 5/12/2024 indicating that she changed the bandage as ordered. An interview was conducted on 5/15/2024 at 3:25 pm with the Director of Nursing. She reviewed the TAR for Resident #32 with the surveyor. She confirmed the check in the box under the date indicated the treatment was done. She confirmed the treatment order was for every other day. She stated the bandage should have been changed 5/10/2024, 5/12/2024, and 5/14/2024. She was shown the picture of the dressing taken on 5/13/2024 at 12:40 pm reflecting 5/8/2024. She stated there should not have been a check mark under 5/10/2024 nor 5/12/2024 indicating the treatment was done. She stated the nurse should have documented why the treatment was not done. Review of the facility policy for Documentation in Medical Record, reviewed/revised on 1/4/2024, revealed the following: Policy: Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. Per Policy Explanation and Compliance Guidelines: 1. Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy. 3. Principles of documentation include but are not limited to: a. Documentation shall be factual, objective, and resident centered. i. False information shall not be documented. b. Documentation shall be accurate, relevant, and complete, containing sufficient details about the resident's care and/or responses to care. 45673