| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105979 | A. Building<br>B. Wing | 07/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Solaris Healthcare Coconut Creek | 4125 West Sample Rd<br>Coconut Creek, FL 33073 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36734<br><br>Based on observation, interview and record review, the facility failed to meet professional standards of quality practice during administration of an insulin pen for 1 of 1 sampled resident observed for insulin administration (Resident #60).<br><br>The findings included:<br><br>Review of the Quick Reference Guide for Lantus SoloStar, copyright 2008, provided by the facility, documented the following:<br><br>1. Attach a new needle.<br><br>2. Perform a safety test, this removes air bubbles and ensures that the pen and needle are working properly.<br><br>Take off the needle cap. Hold the pen with the needle pointing upward and press the injection button all the way in. Check if insulin comes out of the needle. If insulin does not come out, you must repeat the test until it does. If no insulin comes out after doing the test 3 times, change the needle for a new needle and try again.<br><br>3. Select your dose.<br><br>4. Inject your dose.<br><br>5. Remove the needle.<br><br>Record review documented Resident #60 was admitted to the facility on [DATE] with diagnoses that included Diabetes. Record review revealed a comprehensive assessment dated [DATE] that documented the resident had moderate cognitive impairment.<br><br>A medication administration observation was conducted on 07/24/24 at 8:50 AM for Resident #60 with Staff H, Licensed Practical Nurse/LPN. Staff H was observed with an insulin pen containing NPH insulin. Staff H was observed using an insulin syringe to extract 18 units of insulin from the insulin pen. Staff H was observed squinting his eyes and fumbling with the syringe plunger to obtain 18 units of insulin. Staff H proceeded to inject the insulin into Resident #60's arm.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Record review revealed a physician order for Humulin NPH Insulin 18 units subcutaneous twice a day, before breakfast and before dinner for Resident #60.<br><br>An interview was conducted with Staff H on 07/24/24 at 11:00 AM. The surveyor questioned Staff H on why he used an insulin syringe to extract the insulin from the insulin pen. Staff H stated he knows it was bad practice, but the facility does not always have needles for the insulin pen available. Staff H acknowledged insulin pen needles were available for Resident #60's insulin pen.<br><br>An interview was conducted with the Director of Nursing (DON) on 07/24/24 at 2:00 PM. The DON stated insulin pens should be used as they are designed to be used. |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50370<br><br>Based on observations, interviews, and record reviews, the facility failed to identify, monitor, and implement interventions consistent with the residents' needs, facility goals, and current Professional Standards of Practice to maintain acceptable parameters of nutritional status for residents receiving tube feeding, for 1 of 3 sampled residents, Resident #87; and failed to obtain weekly weights and verify weights as needed for 1 of 3 sampled resident, Resident #87.<br><br>The findings included:<br><br>1. Record review revealed Resident #87 was admitted on [DATE] and readmitted on [DATE] with diagnoses that include Metabolic Encephalopathy (a condition where changes in how the brain works occurs due to an underlying condition, causing confusion, memory loss and loss of consciousness), Pressure Ulcer of sacral region, stage 4, and Cachexia (a condition where there is an unintentional decrease in body weight without trying, which could be the result of stress, changes in diet or appetite, and medication side effects).<br><br>Record review revealed Resident#87's weight as follows:<br><br>On the admitted [DATE] was 100 pounds.<br><br>On 06/08/24, a day after readmission, the recorded weight was 99 pounds.<br><br>On 07/23/24 at 3:00 PM, a weight of 93.4 lbs. was obtained by the facility's 2 Certified Nursing Assistants (CNAs) with the Registered Dietician (RD) and 2 surveyors present. This weight signified a 6.6% weight loss.<br><br>Review of physician orders dated 06/07/24 and 06/12/24 revealed the following: Jevity 1.5 @ 65ml per hour x 11 hours via peg (percutaneous endoscopic gastrostomy tube) from 8pm-7am; Bolus 1 carton (240ml) Jevity 1.5, via peg on 06/12/24; Check residual before starting tube feeding. If residual is 60 cc or greater, hold feeding and recheck in one (1) hour. If residual still 60 cc or greater, continue to hold feeding and call physician; Flush Peg with 60cc H2O (water) before and 60cc H2O after bolus (Total:120cc) dated 06/12/24; Flush peg, via pump with 60ml H2O per hour x 11 hours (8pm-7am) dated 06/07/24.<br><br>Additional review of orders, dated 06/07/24, documented Resident #87 is on pureed consistency with thickened liquid diet, and may have food for pleasure.<br><br>An observation was conducted on 07/23/24 at 7:40 AM of Resident #87 who was noted in her bed with the tube feeding off. The tube feeding was noted with Jevity 1.5 at 65 ml an hour which was started the night before on 07/22/24 at 8:00 PM. The tube feeding was noted at the 500ml level out of a 1000ml capacity bottle. This showed that 500ml was infused over the 11 hours and not the 715 ml of formulary that needed to be infused in 11 hours. When the RD was asked about the caloric and nutritional significance of not receiving the full ordered volume of tube feeding, he stated Resident #87 was short on 322 kcal for the night tube feeding.<br><br>(continued on next page) |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An observation was conducted on 07/24/24 at 7:20 AM of Resident #87 who was noted in her bed with the tube feeding off. The tube feeding was noted with Jevity at 65ml an hour, which started the night before on 07/23/24 at 8:00 PM. The tube feeding was noted at the 400ml level out of a 1000ml capacity bottle. This showed that 600 ml was infused from last night in 11 hours and not the 715ml of formulary that needed to be infused in 11 hours. This shows that Resident #87 was short of 172 kcal for her night feeding.<br><br>In an interview conducted on 07/23/24 at 7:50 AM with Staff A, RN (Registered Nurse), he stated the following: when he arrived at 11 PM last night, the tube feeding was already running which had started at 8PM last night. Resident # 87 was tolerating the tube feeding all night and it was running all night. He stopped the tube feeding for 5-10 minutes for cleaning and medication administration.<br><br>In a follow-up interview conducted on 07/24/24 at 7:50 AM with Staff A, RN, he stated the following: when he arrived at 11 PM last night, the tube feeding was already running which had stated at 8PM last night. Resident # 87 was tolerating the tube feeding all night and it was running all night. He stopped the tube feeding for 5-10 minutes for cleaning and medication administration.<br><br>In an interview with the RD (Registered Dietician) on 07/24/24 at 8:47 AM, he stated that facility staff acquire and record the residents' weights on admission, and every week for 4 weeks for the first month. The facility's goal is to have a PIP (Process Improvement Project) on weights which is a continuing progress, and has been ongoing since it started during COVID-19 pandemic. He had been doing it with steps and being realistic with goals. He added that acquiring at least the residents' admission weights is still not accomplished. He recognized this, so he created a list of residents who needed monthly and weekly weights and provided it to the Nursing Staff, to guide them in tracking residents who needed weights. He stated that the list is updated weekly.<br><br>The RD stated that the CNAs, Therapy Personnel, and RD are responsible for obtaining the residents' weights. The facility does not have a designated person for weight taking. He added that he created a worksheet that would easily identify residents who needed weekly or monthly weights monitoring. He stated residents' weights are discussed weekly during a clinical meeting. He acknowledged that weekly weighing, and monitoring of residents' weights are not done, so the staff, including him, are working on this goal.<br><br>When asked if he had a concern about a resident who is losing weight, he stated that he would ask the staff to obtain the weight for that resident right away. He added that he considers residents with high nutritional risks are those who are receiving tube feeding, undergoing dialysis treatment with ESRD (End Staged Renal Disease), and those with wounds.<br><br>When asked about a resident with pressure ulcers, he stressed that he would estimate the nutritional needs between 1.2 to 1.5 grams per KG (kilogram) of body weight. For residents on tube feeding, the weight loss would be an indication that they are not receiving the tube feeding as ordered.<br><br>When asked about Resident #87, the RD stated Resident #87 is receiving Jevity 1.5 at 65 ml(milliliter) an hour times 11 hours that would be providing: 1072 Kcal. ~45g protein, and 543cc free H2O from the continuous tube feeding. The Bolus 1 carton (240ml) via peg is administered at 2 PM which provides ~355 Kcal, ~15g (Gram) protein. In total, Resident #87 receives 1427 kcal and 60 grams of protein.<br><br>(continued on next page) |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | According to this RD, pleasure feeding does not add any extra caloric or protein value and 100% of Resident #87's nutritional needs are provided by the tube feeding. He also recognizes that Resident #87 is at nutritional risk. He added that he looks for symptoms of hydration and Resident #87's weights are good indicators of her nutritional wellbeing. He added that since Resident #87's readmission, the facility had taken and recorded only two weights for this resident.<br><br>In an interview conducted on 07/25/2024 at 1:35 PM, the Nursing Home Administrator was informed of the findings above. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50370<br><br>Based on observations, interviews, and record reviews, the facility failed to ensure timely labeling and changing of oxygen tubing consistent with the Professional Standards of Practice for residents who are receiving oxygen for 2 of 2 sampled residents reviewed for oxygen therapy, Resident #22 and Resident # 86).<br><br>The findings included:<br><br>1. Record review of Policy, titled, Nursing Services Policy and Procedure Manual for Solaris Healthcare, revised on 01/25/23, showed to verify the physician's order or the facility protocol for oxygen administration.<br><br>Record review documented Resident #22 was admitted on [DATE] with the diagnoses that included Acute Bronchospasm, and Degenerative Disease of Nervous system.<br><br>Review of physician orders dated 05/09/24 stated to provide oxygen at 2 Liters per minute through nasal cannula continuously every shift.<br><br>In an observation during lunch on 07/22/24 at 12:30 PM, Resident #22 had oxygen delivered through nasal cannulae on both nares at 2 Liters per minute. Closer observation revealed the oxygen tubing was dated 07/12/24, with no staff initial.<br><br>In another observation on 07/23/24 at 3:00 PM, Resident #22's oxygen tubing had the same dated tag of 07/12/24. There were no staff initial observed on the tubing tag. In this observation, Resident #22 stated she receives oxygen therapy 2 to 3 times a day.<br><br>On 07/23/24 at 8:34 AM, Resident #22 was observed eating breakfast, with the nasal cannulae in both nares. The Oxygen tubing was still dated 07/12/24.<br><br>In an interview with the Director of Nursing (DON) on 07/23/24 at 4:10 PM, she stated when residents receive oxygen orders, the facility staff are expected to routinely monitor the oxygen delivery and to verify the orders based on physician's parameters such as oxygen saturation (the percentage of oxygen that is bound in red blood cells). She further stated that the oxygen tubing must be changed weekly on Sundays during night shift between the hours of 11 PM and 7 AM. This is done to start the week fresh, and when oxygen tubing falls to the ground / floor, staff must change the tubing immediately.<br><br>2. Record review of Policy, titled, Nursing Services Policy and Procedure Manual for Solaris Healthcare, revised on 01/25/23, showed to verify the physician's order or the facility protocol for oxygen administration.<br><br>Record review documented Resident #86 was admitted on [DATE] with a diagnosis of Acute Respiratory Failure with hypoxia (low oxygen level in the blood stream).<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of physician orders dated 07/15/24 documented the Oxygen is to be administered at 2 Liters per minute via nasal cannula every shift as needed for shortness of breath.<br><br>During an observation on 07/22/24 at 11:00 AM, Resident #86 stated the oxygen is administered as needed. The Oxygen tubing was dated 07/10/24.<br><br>During an observation on 07/23/24 at 4:00 PM, Resident #86 was seen without the oxygen cannulae in both nares. Closer observation revealed the oxygen tubing was on the floor with a date noted as 07/10/24.<br><br>In an interview with Staff B, RN (Registered Nurse) on 07/23/24 at 4:30 PM, he stated the oxygen tubing must be changed, but he did not remember the frequency. He remembered that the facility policy was to change oxygen tubing during the night shift but could not remember if it was done on a weekly basis.<br><br>In another interview with Staff C, LPN (Licensed Practical Nurse), on 07/23/24 at 4:40 PM, she stated the oxygen tubing is changed weekly on Sundays during night shift between11 PM to 7 AM.<br><br>During an interview conducted with the Nursing Home Administrator on 07/25/24 at 1:35 PM, the above findings were reviewed. |

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| F 0867<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40153<br><br>Based on observations, interviews, and record review, the facility failed to develop and implement an effective Quality Assurance and Performance Improvement Program (QAPI) with appropriate plans of action, as evidenced by failure to regularly review and analyze data and act on available data to make improvements regarding obtaining resident's weights as per the facility's policy for 3 of 3 sampled residents reviewed for tube feeding (Resident #87, Resident #96 and Resident #56).<br><br>The findings included:<br><br>Review of the facility's policy, titled, Quality Assurance and Performance Improvement Program (QAPI), dated 01/24/23, revealed the following:<br><br>It is the policy to develop and implement appropriate plans of action to correct and identify quality deficiencies. The policy also requires regularly reviewing and analyzing data, including the data collected under the QAPI program, and acting on available data to make improvements.<br><br>Review of the facility's policy, titled, Weights, dated 01/12/21, revealed the following:<br><br>The resident is weighted upon admission or readmission within 24 hours by the nursing staff and recorded in the medical record. The resident is then weighed weekly for four weeks by designated nursing staff. Weekly weights are continued or recommended as determined by the Interdisciplinary Team.<br><br>1. Record review documented Resident #87 was readmitted to the facility on [DATE] with diagnoses to include Parkinsonism, Dementia, Cachexia (weight loss/muscle loss), and Muscle weakness.<br><br>Review of Physicians' orders showed an order for Jevity 1.5 (tube feeding formulary) at 65 milliliters (ml) an hour for 11 hours, which was dated 06/07/24. An order for bolus feeding one carton of Jevity 1.5 was dated 06/07/24.<br><br>Review of Resident #87's weight log showed the following: a readmission weight of 100 pounds dated 06/08/24; the next weight was taken on 07/05/24 (a month later) at 99 lbs. This revealed that no weekly weights were done after the initial readmission weight.<br><br>2. Record review revealed that Resident #96 was admitted on [DATE] with diagnoses to include Hemiplegia, Dementia, and Anxiety. A physician order dated 05/23/24 documented for Jevity 1.5 (tube feeding formulary) at 55 milliliters (ml) an hour for 20 hours, off from 9:00 AM to 1:00 PM.<br><br>A review of the weights log showed the following: taken on 12/04/23, 01/04/24, 02/5/24, 03/27/24, 05/20/24, 06/07/24, and 07/05/24. This showed that the weekly weights were not done after Resident #96 was admitted on [DATE], and a monthly weight was missed for the month of April 2024.<br><br>(continued on next page) |

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| F 0867<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 3. Record review revealed that Resident #56 was readmitted on [DATE] with diagnoses of Hemiplegia, Hypertension, and Heart Disease. A physician order dated 04/18/24 documented for Jevity 1.5 at 60ml an hour for 11 hours from 8:00 PM to 7:00 AM. A physician order dated 04/19/24 documented for Jevity 1.5 carton bolus feeding twice a day.<br><br>Review of the weight log showed weights were obtained on 04/20/24, 05/06/24, 06/7/24, and 07/05/24. This showed that the weights were not taken every week for four weeks after Resident #56's readmission on 04/18/24.<br><br>In an interview conducted on 07/24/24 at 8:47 AM, the facility's Registered Dietitian stated that they have had an issue with weekly weights not being taken and monthly weights needing to be taken in a timely manner. They have started a Performance Improvement Plan (PIP) after COVID-19, and it is ongoing in the facility. The facility's staff are recording the admission weights of all residents but have not been able to accomplish the weekly weights steadily. He stated he is responsible for the PIP on weights and created a list of residents on a weekly basis, looking at monthly and weekly weights. The list of residents with missing weights is given to the nursing staff, and it is the responsibility of nursing, rehab, and himself to obtain all missing weights. The facility does not have a specific person designated to take weights on all residents. Weights are discussed weekly during clinical meetings and overall missing weights that are due.<br><br>In an interview conducted on 07/25/24 at 11:30 PM, the Administrator stated that a QAPI review was started on weights in January 2024. A QAPI will be started with specific goals in place and will be reassessed after three months. The Registered Dietitian oversaw tracking monthly and weekly weights with a goal of 100%. Afternoon meetings are conducted with the nursing team, the Registered Dietitian gives them a list of any missing weights according to his daily list of residents. According to the facility's administration, the QAPI on weights is between 95% to 98% of the 100% goal for weekly weights and 30% to 48% of the 100% goal for monthly weights. The monthly weights have improved, and they are almost at the goal for weekly weights.<br><br>In an interview conducted on 07/25/24 at 12:15 PM with the Registered Dietitian, he reported that the QAPI for the resident's monthly weights is going well, but the resident's weekly weights are not. He is still working on the QAPI for June 2024, but the data for the weekly weights is not good so far. When asked about the weight QAPI for the month of May 2024, he said that it is at 100% of the monthly weights and 0% for the weekly weights. He further stated that he had not been tracking the weekly weights because he wanted to concentrate on ensuring that monthly weights were being done, and was going to look at weekly weights in the future. When asked about other effective systems to identify, collect, and use regarding weekly and monthly weights, he did not answer. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50370<br><br>Based on observations, interviews, and record reviews, the facility failed to follow infection control practices and failed to follow the Facility' Standards of Practice for Neutropenic Precautions for 1 of 1 sampled resident reviewed for Transmission Based-Precautions, Resident #463.<br><br>The findings included:<br><br>Record review documented Resident #463 was admitted on [DATE] with diagnoses to include Hepatic Encephalopathy (A loss of brain function because of failure in the removal of toxins from the blood due to liver damage), Autoimmune Hepatitis (A chronic disease that causes liver inflammation when the body's immune system attacks the liver cells), and Cognitive Communication Deficit.<br><br>Record review of the Minimum Data Set (MDS) assessment of 07/19/24 revealed it was skipped and a new MDS evaluation was in process on 07/23/24.<br><br>Review of laboratory results performed on 07/20/24 revealed Resident # 463's blood level of WBC (White Blood Cells are the body's main defense against infection) was 1.9, which was below the normal range of 4 to 11, indicating Resident #463 is at very high risk of acquiring infection.<br><br>Review of the physician's orders dated 07/21/24 showed the following:<br><br>Neutropenic Precautions every shift as precautionary measures; Special Instructions including the appropriate use of PPE [Personal Protective Equipment] and hand washing; Resident education on good handwashing, coughing, sneezing etiquette, and documenting in progress notes every shift.<br><br>Review of Progress Notes dated 07/24/24 at 2:54 PM documented Resident #463 was to, continue with Neutropenic Precautions associated with the risk for infection. Patient is to be reminded to: clean hands frequently, avoid contact with sick people, wear mask, carefully wash raw fruits and vegetables, use soft toothbrush, and say no to fresh flowers. Additional notes showed the resident verbalized understanding, and a copy of Neutropenic Precautions guidelines was given to the resident and her spouse.<br><br>During observation on 07/22/24 at 10:45 AM, the resident's visitor was inside the room. He was not wearing a facial mask or gloves. When asked why, the visitor stated Resident #463 is the one who needs to wear a facial mask, but he did not remember if he is supposed to wear a facial mask too. When asked if staff educated him about the signage outside Resident #463's door, he stated, I do not remember.<br><br>During the same observation on 07/22/24 at 10:55 AM, Resident #463's door signage showed the following: Neutropenic Precautions; wash hands with soap and water before entering and leaving the room; wear mask, gown and gloves as PPE. Further observation showed an open shelving of supplies consisting of a box of mask, yellow disposable gowns, a box of gloves, rolled red bags, and a yellow linen gown, located outside, elevated from the ground, and on the left side of Resident #463's door.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105979 | A. Building<br>B. Wing | 07/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Solaris Healthcare Coconut Creek | 4125 West Sample Rd<br>Coconut Creek, FL 33073 |

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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Continuation of observation on 07/22/24 at 12:15 PM, showed Staff D, CNA, was inside Resident #463's room without wearing a PPE gown. She was observed wearing a facial mask covering her nose and mouth. She was inside Resident #463's room preparing the meal table and pushing it towards Resident #463. She removed her mask inside the room and performed ABHR when she stepped outside.<br><br>Continued observation on 07/22/24 at 12:18 PM showed Staff D bringing the lunch tray inside Resident #463's room. She did not perform hand washing or hand sanitizing before entering Resident #463's room. She did not put on gloves, a facial mask or a disposable gown as PPE. Staff D placed the lunch tray on the meal table but did not encourage hand washing or hand sanitizing to Resident #463 and her husband. Resident #463's husband was observed giving utensils to Resident #463 and started touching the inside of the meal tray. Closer observation revealed Resident #463's husband was not wearing a facial mask, a gown or gloves.<br><br>Further observation on 07/22/24 12:46 PM showed Resident #463's visitor went inside the room without performing hand sanitizing, and putting on a facial mask, gown and gloves. He stated he was opening a food container and eating with Resident #463. This visitor was seen and heard coughing without covering his mouth or following a proper cough etiquette while eating with Resident #463.<br><br>In an observation on 07/23/24 at 9:02 AM, Staff E, CNA, was observed to put on a disposable yellow gown outside the resident's room. She did not put on a facial mask or set of gloves. She did not perform hand washing with soap and water or sanitized her hands with ABHR. She went inside the resident's room and talked to Resident #463. She left the room after taking the yellow gown off inside and performed ABHR outside on 07/23/24 09:04 AM.<br><br>In an observation on 07/23/24 at 2:00 PM, Resident #463 was observed being wheeled towards the main area of the facility by her husband. Upon closer observation, Resident #463's blue facial mask was seen underneath her nose, mouth and chin.<br><br>In an interview with the Director of Nursing (DON) on 07/22/24 at 1:55 PM, regarding the facility's protocol for Neutropenic Precautions, she stated the staff are educated about precautions established by CDC (Center for Disease Control and Prevention) such as Enhanced Barrier-Precautions, Transmission Based-Precautions, Standard Precautions, and Neutropenic Precautions, together with the corresponding appropriate guidelines, and recommendations during Staff orientation.<br><br>When asked how she instructed the staff regarding Neutropenic Precautions for Resident #463, she stated staff were educated to perform hand washing with soap and water, concurrent with wearing a facial mask, gloving both hands, and donning a disposable gown when entering Resident #463's room. She added ABHR (Alcohol-Based Hand Rub) may be performed together with hand washing with soap and water when entering Resident #463's room. She stressed that hand washing with soap and water is an absolute must before Staff enters Resident #463's room.<br><br>(continued on next page) |

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| | 105979 | A. Building<br>B. Wing | 07/25/2024 |

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| Solaris Healthcare Coconut Creek | 4125 West Sample Rd<br>Coconut Creek, FL 33073 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview with Staff G, Certified Nursing Assistant (CNA) on 07/24/24 at 2:18 PM, who has been working in the facility for 10 months, she stated, for residents with Neutropenic Precautions, one requirement is for the resident to be in a private room; flowers and multiple visitors are not allowed; need to check for bruises on resident's skin; the Neutropenic Precaution is a condition which requires staff to care for both the resident's and staff's well-being; Staff must wear gloves in any procedures requiring contact with the resident; Staff must wash hands with water and soap for 20 seconds, put on gloves, and then start caring for the resident. Staff G added that staff must use gloves when touching the resident. When leaving the resident's room, staff must remove gloves and wash hands using soap and water.<br><br>In an interview on 07/24/24 at 2:40 PM with Staff F, Registered Nurse (RN), who has been working in the facility for three months, she stated Neutropenic Precautions is for resident with low WBC (White Blood Cell). It is a form of Contact Precaution, where Staff must wash hands, and resident must wear mask. Staff must educate residents about the Neutropenic Precaution as follows: Resident is prevented from going into a crowded room; from having skin cuts; Resident must always wear mask; and wash hands with soap and water. According to Staff F, the following are the recommended guidelines for the Facility Staff and Visitor: Staff must wear PPE (Personal Protective Equipment) such as mask, gown and gloves, if doing direct care. Staff must educate visitors not to bring raw food. Visitors are not required to wear a gown but just a mask.<br><br>When asked when she educated Resident #463's visitor concerning hand washing with soap and water and wearing a mask, she stated she taught him to perform ABHR before getting inside Resident #463's room and to let the alcohol dry for one minute. She stated she taught all these guidelines yesterday.<br><br>An interview was conducted with the Nursing Home Administrator on 07/25/24 at 1:35 PM, who was made aware of the above findings. |