STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106011	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kissimmee Nursing & Rehabilitation Center	2511 John Young Parkway North Kissimmee, FL 34741

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** 51023 Based on observation, interview, and record review, the facility failed to provide the necessary treatment and services to promote healing and prevent worsening of existing pressure ulcers for 3 of 13 residents reviewed for pressure ulcers, of a total sample of 20 residents, (#3, #9, and #17). Findings: According to the National Pressure Ulcer Advisory Panel (NPUAP), There are Stage 1 to 4 pressure ulcers, unstageable and suspected deep tissue injury (SDTI) .Stage 2 has partial thickness loss of dermis presenting as a shallow open ulcer with red/pink wound bed, without slough .Stage 3 has full thickness skin loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed . Stage 4 has full thickness tissue loss with exposed bone, tendon or muscle Unstageable depth is unknown and presents with full thickness tissue loss in which the base of the ulcer is covered by slough (dead tissue) .SDTI has depth unknown presenting as purple or maroon localized area of discolored intact skin or blood blister due to damage of underlying soft tissue from pressure and /or shear .(retrieved from www.NPIAP.com on 6/25/24). 1. Resident #3 was admitted to the facility on [DATE] from an acute care hospital with diagnoses including cerebral atherosclerosis, vascular dementia, type 2 diabetes mellitus, chronic kidney disease, heart failure, and anemia. Resident #3 was admitted to hospice services as of 3/13/24 for a diagnosis of cerebral atherosclerosis. The resident's Minimum Data Set (MDS) assessment dated [DATE] indicated she had moderately impaired decision making and needed cues and supervision. Her Brief Interview for Mental Status (BIMS) was listed as '99' which correlated as being unable to complete the interview. The assessment described her as dependent for all activities of daily living (ADL) and unable to turn herself in bed. Resident #3 was always incontinent of urine and bowel. The assessment indicated the resident was admitted with a stage 3 pressure ulcer. Resident #3's care plan initiated 4/08/24 listed the resident as having the potential for pressure injury development related to dementia, history of ulcers, immobility, potential for friction and shear, limited bed mobility, limited sensory perception and high risk per Braden Scale. The resident was also at risk for altered nutritional status related to multiple diagnoses, advanced age, mechanically altered diet, polypharmacy, and impaired skin integrity. The resident had potential/actual impairment to skin integrity related to fragile skin, and incontinence. The care plan indicated the resident had bladder and bowel incontinence. (continued on next page)

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	A review of resident #3's medical record revealed the following physician orders started 3/28/24 for 28 days and ended on 4/21/24. The treatment order stated cleanse sacrum with normal saline, pat dry then apply collagen sheet with silver and cover with bordered gauze daily and as needed. No treatment orders were noted after 4/21/24. A wound evaluation by the Wound Specialist physician on 5/09/24 listed the treatment plan for the primary wound was to apply Zinc ointment, once daily for 30 days. Neither the resident's Treatment Administration Record (TAR) nor clinical record showed any orders for zinc ointment to be applied. Wound evaluation by the Wound Specialist physician on 5/16/24 listed the treatment plan for the primary dressing was Zinc ointment apply once daily for 23 days and Alginate Calcium apply once daily for 23 days. The secondary dressing was listed as superabsorbent gelling fiber with silicone border & face apply once daily for 23 days. Neither the resident TAR nor the clinical record showed any orders for this treatment plan. A wound evaluation by the Wound Specialist physician on 5/23/24 described the treatment plan for the primary dressing was Zinc ointment apply once daily for 16 days and Alginate Calcium apply once daily for 16 days. The secondary dressing was listed as superabsorbent gelling fiber with silicone border & face apply once daily for 16 days. Again, neither the resident's TAR nor the clinical record showed orders for this treatment plan. Another wound evaluation by the Wound Specialist physician on 5/30/24 listed a new treatment plan for the primary dressing was Alginate Calcium with silver apply once daily for 30 days. The secondary dressing was listed as superabsorbent gelling fiber with silicone border & face apply once daily for 16 day. Again, neither the resident's TAR nor clinical record showed orders for this treatment plan. On 6/12/24 at 10:19 AM, assigned Registered Nurse (RN) A stated she could not remember if the resident had a dressing on her sacrum but said the wounds were getting better. She then proceeded to pull up the electronic Medication Administration Record (eMAR) and confirmed resident #3 only had an order for barrier cream to the area, not for the wound treatment. She stated according to the record there was no dressing on the area. At 11:34 AM on 6/12/24, the surveyor accompanied the Director of Nursing (DON) to observe resident #3's sacral wound. The resident gave approval to observe her sacral wound and the DON donned her gloves and removed the resident's brief. Her sacral wound was noted to have only barrier cream with no dressing. The DON confirmed no dressing was in place. On 6/12/24 at 11:08 AM, the DON revealed the Wound Specialist physician came to the facility every Thursday. She explained the past Thursday, 6/06/24 they did not come due to a medical emergency. The Assistant DON handled the wound care on Thursday when the Wound Specialist was unable to come. She said typically the Unit Manager (UM) was in charge of adding the wound care treatment orders from the Wound Specialist in the resident's electronic medical record. In a telephone interview on 6/12/24 at 1:31 PM, the Wound Specialist physician revealed he just finished a telehealth visit to assess Resident #3's wounds. He stated they were getting better. He also stated he understood that the wound care orders were not being followed and his expectations were that wound orders were to be followed as written. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/12/24 at 2:03 PM, the Assistant DON revealed her responsibilities included infection control, and managing the UMs to make sure they did their job. When she started a few months ago, she was assigned to cover the UM position since the spot was vacant. Every Thursday, she rounded with the Wound Specialist physician. Her job was to follow the doctor and observe his wound care treatments. She also checked measurements of the wounds and wrote them down. She then gave the paperwork to the DON who checked to see if the wounds had improved. She stated she knew there needed to be a treatment order before performing any wound care. She stated she did not check the medical record for the orders. She agreed there was no documentation that wound care was performed on Resident #3 after 4/21/24. On 6/12/24 at 3:44 PM, the DON revealed the facility gave the Wound Specialist physician a new list of people each week to see. She explained typically the UM was the person who rounded with the doctor. The DON's expectations for the UMs while rounding with the doctor, were to visualize the wounds themselves, write down the measurements the doctor gave them, and write down any changes to the treatment orders. She said the Wound Specialist physician would upload his evaluations into the system himself and the UM was expected to look at the uploaded wound evaluation. The DON described the UMs or ADON would put the orders into electronic record. She recounted that once a week, she reviewed all of the wounds in the building to see their progress. She stated she only reviewed the wound evaluations from the Wound Specialist physician and did not look at the eMAR at all when reviewing wounds. The DON stated the UM on the unit had only been working at the facility for under a week, before she started, the Assistant DON covered those responsibilities. 2. Resident #17 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy, cellulitis of back, muscle weakness, and severe protein malnutrition . The resident's MDS assessment dated [DATE] indicated his BIMs was 13/15 which correlated to being cognitively intact. He was listed as needing partial or moderate assistance with toileting hygiene and personal hygiene. Resident #17 was always incontinent of urine and bowel. The assessment indicated the resident was admitted with one or more unhealed pressure ulcers/injuries including one stage 4 pressure ulcer. Listed under skin and ulcer/injury treatments were pressure ulcer/injury care, application of nonsurgical dressings other than to feet and applications of ointments/medications other than to feet. Resident#17's care-plan initiated 5/21/24 listed the resident as having a pressure injury and potential for pressure injury development related to a right heel pressure wound stage 4, pressure injury to right, medial upper back and wound to right, upper lateral back. Interventions included administering treatments as ordered and give supplemental vitamins and minerals as ordered to promote wound healing. The care plan indicated the resident had bladder and bowel incontinence. A review of resident #17's clinical record revealed a physician's order for Venelex external ointment on 5/22/24. The instructions stated to apply to upper back, and right heel, topically two times a day for prevent of infection and healed wound right lateral wound, right heel wound, and upper back x2. Review of the clinical record revealed no treatment order was associated with this ointment. A wound evaluation by the Wound Specialist physician on 5/23/24 indicated resident #17 was not seen that day. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A wound evaluation by Wound Specialist physician on 5/30/24 listed the recommendations for pressure off-loading boot, Zinc Sulfate once daily for 14 Days and Vitamin C twice daily. The treatment plan for the primary dressings to the right heel/medial back/right upper back were Alginate Calcium to apply once daily for 30 days. The secondary dressing was listed as a gauze island with border once daily for 30 days. Review of the resident's clinical record revealed no orders for Zinc Sulfate, nor any treatment orders until 6/12/24. Resident #17 had a previous order for vitamin C once daily which was not updated to the Wound Specialist physician's recommendation of twice a day until 6/12/24. Instead, the resident was noted to have been administered Venelex ointment twice daily from 5/30/24 until 6/12/24. There was no order noted for the pressure off-loading boot. A review of the resident's Progress Notes revealed a note dated 6/12/24 at 6:25 PM, stated the treatment orders were not initiated per physicians' orders, but per the provider the wounds have improved and showed no signs of infection. The note described the wound size had decreased on all 3 wounds. On 6/13/24 at 9:24 AM, the DON and the Regional Nurse acknowledged there were no treatment orders for resident #17. They said staff had been documenting the administration of the Venelex in the eMAR instead of in the TAR. The DON acknowledged the nurses were provided the wrong treatment to Resident #17 since 5/30/24 when the order had changed. 3. Resident #9 was admitted to the facility on [DATE] with diagnoses including encephalopathy, dysphasia, need for assistance with personal care, muscle wasting and atrophy, anxiety, acute osteomyelitis, pressure ulcer of sacral region and heart failure. The resident's MDS assessment dated [DATE] indicated a BIMs of 8/15 which correlated to being moderately impaired cognitively. The assessment also indicated resident #9 needed substantial or maximal assistance with toileting hygiene and moderate assistance with personal hygiene. The assessment showed resident #9 was always incontinent of urine and bowel and was admitted with one or more unhealed pressure ulcers/injuries including one stage 4 pressure ulcer. Resident#17's care plan initiated 4/19/24 listed the resident as having a pressure injury or the potential for pressure injury development related to a mobility deficit. Interventions included staff to administer treatments as ordered and monitor wound healing. Resident #9 also had a care plan for the potential for infection related to chronic wound. Wound evaluation by the Wound Specialist physician on 4/18/24 described the wound vacuum not functioning well and a decision was made to change the treatment. The primary dressing was changed to Alginate Calcium with silver applied once daily for 30 days. The secondary dressing was foam with border applied once daily for 30 days. On 5/30/24 the treatment order was changed again to a collagen sheet with silver applied once daily for 30 days. The secondary dressing was foam with border applied once daily for 16 days. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of resident clinical record revealed a physician order starting on 4/02/24 until 4/16/24 for a wound vacuum to be changed every Tuesday, Thursday and Sunday. On 4/16/24, a physician order was added to 'cleanse sacrum with NS (normal saline), apply CaAg (Calcium Alginate) and cover with foam dressing once a day.' This order was discontinued on 6/12/24. On 6/13/24 a physician order was added, 'sacral wound: cleanse with NS (normal saline), apply collagen sheet with silver, cover with foam border dressings'. Further review of the medical record noted resident #9 received the incorrect treatment of Calcium Alginate without silver from 4/18/24 until 6/12/24. According to the International Wound Journal, incorporating silver into alginate fibers can add antimicrobial properties to help the highly absorbent wound dressing, (retrieved on 6/25/24 from www.onlinelibrary.[NAME].com.).