

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  106072	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/20/2024
NAME OF PROVIDER OR SUPPLIER  Village Place Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2370 Harbor Blvd Port Charlotte, FL 33952	

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)
<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50649</p> <p>Based on clinical record review, review of facility's policy and procedure, staff and residents interviews, the facility failed to ensure grievances filed by residents were promptly reviewed and investigated to keep the residents apprised of progress toward a resolution for 5 Residents (#36, #37, #41, #422, and #272) of 5 residents reviewed for grievances.</p> <p>The findings included:</p> <p>Review of the undated facility's Grievance Policy and Procedure revealed the Social Worker has been given the authority of the Grievance Officer.</p> <p>The Grievance Officer is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusion; leading necessary investigation by the facility; maintaining confidentiality of all information associated with grievances, issuing written grievance decisions to the Resident and coordinating with state and federal agencies as necessary considering specific allegations.</p> <p>Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the Resident 's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the Resident 's concerns, a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued.</p> <p>All grievances will be dated when received, filed in a grievance log and assigned to the appropriate department within 24 working hours. The Director of the involved department will personally investigate the expressed issue or assign investigation to an informed staff member for investigation. This person will speak with all necessary personnel and the complaining party to obtain details and make every attempt to reach a resolution that is satisfactory to the person who expresses the grievance. The Department director or his/her designee will document his/her actions, the resolution, sign and date the form and return the form to the Grievance Official within 7 calendar days.</p> <p>The Grievance Official will follow up with the Resident to ensure that the concern is fully resolved. The complainant has the right to receive a written response containing the results of any investigation and any corrective actions to be put in place.</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>1. Review of the clinical record revealed Resident #41 was admitted to the facility on [DATE].</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment showed Resident #41's cognition was intact with a Brief Interview for Mental Status (BIMS) score of 15.</p> <p>On 6/17/2024 at 12:30 p.m., in an interview Resident #41 said his clothes were lost in the facility laundry approximately two months ago. He filed a grievance. The facility told him they were, working on it. Resident #41 said it's been two months, and his grievance has not been resolved.</p> <p>Review of the grievance log revealed Resident #41 filed a grievance on 5/6/24 for missing clothing items. The form showed the Administrator signed the grievance form on 5/9/24. The grievance form had no documentation of prompt efforts to resolve the grievance or that the resident was kept apprised of progress toward resolution.</p> <p>On 6/18/24 at 11:30 a.m., in an interview Resident #41 said the Administrator collected receipts for the missing clothing and offered to reimburse him. Resident #41 said the Administrator did not reimburse him and did not replace the missing clothes as promised, a long time ago.</p> <p>On 6/19/24 at 9:30 a.m., in an interview the Housekeeping Supervisor said she has been employed at the facility for [AGE] years. She said Certified Nursing Assistant (CNA) Staff U was responsible to label residents' clothes upon admission. She said staff are supposed to make sure the clothes are labeled before taking them to the laundry, but it does not always happen. The Housekeeping Supervisor said she was aware Resident #41 filed a grievance for missing clothes. She said they looked for the clothes, could not find them but did not document anywhere.</p> <p>On 6/19/24 at 2:40 p.m., the Administrator verified Resident #41 filed a grievance on 5/6/24 for missing clothes. He verified the lack of documentation of steps taken to address and promptly resolve the resident's grievance and the date a written decision was issued. He said the grievance should have been resolved by now, and the resident should have been notified.</p> <p>2. Record review showed Resident #36 was admitted to the facility on [DATE]. Resident #36 had a Brief Interview for Mental Status (BIMS) score of 14, indicative of intact cognition.</p> <p>On 6/17/24 at 10:55 a.m., during an interview Resident #36 said she did not like to wear incontinent briefs because, They are just like diapers. She said she requested Pull-Ups, but the facility never provided them. She said she filed a grievance on 3/28/24 without resolution. She would like to keep a bag of Pull-Ups in her room.</p> <p>Resident #36 said since they did not provide the Pull-Ups, she must sit bare butted in her wheelchair and it makes her feel embarrassed.</p> <p>Review of the grievance log showed on 3/28/24 Resident #36 filed a grievance which noted, Wishes to have a bag of adult Pull-Ups in her room. There was no documentation that the resident's grievance was addressed.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 6/20/2024 at 9:55 a.m., Resident #36 said she had told Staff AA, Staff BB, and Staff CC that she wanted Pull-Ups. The resident said she was getting ready to file another grievance since the facility did not address her previous grievance on 3/28/24. She stated, its few and far between that she can get Pull-Ups.</p> <p>3. Record Review, Resident #37 has a BIMS score of 15, indicating cognitively intact.</p> <p>On 6/17/2024 at 10:25 a.m., in an interview Resident #37 said she has been at the facility since they reopened in March 2024. She's been asking for size extra, extra-large (XXL) Pull-Ups since she returned to the facility but has not received any. Resident #37 said she's asked several staff members since March 2024.</p> <p>On 6/19/24 at 10:20 a.m., observation of the central supply room revealed no XXL Pull-Ups were available for residents' use.</p> <p>On 6/19/2024 at 10:30 a.m., in an interview, Staff F said she was responsible for ordering supplies, including Pull-Ups for residents. Staff F verified there were no XXL Pull-Ups available for residents who needed them.</p> <p>On 6/20/24 at 9:30 a.m., Resident #37 said she cuts out the absorbent pads from smaller Pull-Ups and places them in her underwear, but they slide off every time she pulls her pants up or down.</p> <p>Review of the grievance log from March 2024 to 6/20/24 failed to reveal the resident's grievance was documented and addressed.</p> <p>46824</p> <p>Clinical record review revealed Resident #272 was admitted to the facility on [DATE]. The emergency contact listed was his spouse.</p> <p>Resident #272 diagnoses included Chronic Obstructive Pulmonary Disease, muscle weakness, hypertension, and malignant neoplasm of lung (lung cancer).</p> <p>A physician order dated 4/21/24 at 10:02 p.m., said, Transfer to ER (emergency room ) for eval and tx [treatment].</p> <p>A nursing progress note documented on 4/22/24 at 2:12 a.m., spoke with ER and wife at ER, resident being admitted with UTI (Urinary Tract Infection), dehydration, AKD (Acute Kidney Disease).</p> <p>On 6/18/24 at 5:30 p.m., Resident #272's spouse said in a telephone interview she filed a grievance with the facility because no one called to tell her husband was transferred to the hospital. She said, No one called to tell me anything or follow-up since I filed the grievance.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A grievance report written by the Social Service Director (SSD) on 4/20/24 at 10:00 a.m., documented, wife was upset that she was not notified that Resident #272 was transferred to the hospital for Covid. The findings documented from the grievance investigation noted, spoke to the Director of Nursing about the wife not being notified. The written response documented on the grievance form said, the wife had Resident #272 transferred to [another facility]. The grievance form was signed by the Social Service Assistant (SSA) on 4/25/24 on the line that says, signature of investigating employee.</p> <p>On 6/19/24 at approximately 9:30 a.m., the Social Service Assistant (SSA) and Regional Social Service Consultant were interviewed. The SSA said she signed the grievance form but did not investigate the allegation. She said she did not speak with or call Resident #272 spouse to follow up.</p> <p>On 6/19/24 at 10:40 a.m., the Administrator said he reviewed the grievance form and signed it on 4/25/24. He did not realize it had not been resolved and thought the family had been called.</p> <p>38570</p> <p>Review of the facility policy titled, Investigating Incidents of Theft and/or Misappropriation of Resident Property revised April 2017 specified:</p> <p>3. Our facility will exercise reasonable care to protect the resident from property loss or theft, including:</p> <p>a. Implementing policies that strictly prohibit, and pursue to the full extent of the law, staff or employee theft or misappropriation of resident property.</p> <p>b. Providing measures to safeguard resident valuables from easy public access.</p> <p>c. Inventorying resident belongings upon admission.</p> <p>Review of the Admission Record revealed Resident #422 was admitted on [DATE]. Diagnoses included: Dementia, cystitis, hypertension, hyperlipidemia, diabetes, obstructive sleep apnea and depression.</p> <p>The Admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #422 had a Brief Interview for Mental Status (BIMS) score of 4, which indicated the resident had severe cognitive impairment.</p> <p>A review of Resident #422's care plans revealed the resident is at risk for decreased social interaction/activity participation due to cognitive impairment. And that resident is at the facility for short stay placement. Plans to discharge facility when medically cleared. Date Initiated: 5/15/2024.</p> <p>A review of Resident #422's Inventory of Personal Effects dated 5/13/24 noted the resident had the following items on admission:</p> <p>5 - Blouses/Shirts</p> <p>1 - Slacks/Trousers</p> <p>2 - Shorts/Capris</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>1 - Nightgowns</p> <p>1 - Panties/Briefs</p> <p>2 - Bras</p> <p>2 - Dentures - Upper/Lower</p> <p>1 - Glasses</p> <p>1 - Cell phone - no charger</p> <p>1 - Resmed C-Pap machine</p> <p>1 - Grey thumb ring</p> <p>1 - Purple Beaded Bracelet</p> <p>The form was signed by Resident #422 and staff on 5/13/24.</p> <p>During an interview on 6/17/24 at 10:01 a.m., Resident #422's niece stated that her mother who is the resident's sister reported to her the incident that happened at the facility. She felt she had to report the issue. She said when Resident #422 was admitted on [DATE], the family had brought the items listed above to the facility. When the family came to pick up the resident, all she had left was a dress and one bra. All the other items were missing.</p> <p>During a telephone interview on 6/20/24 10:20 a.m., Residents #422's daughter stated after her mother was admitted on [DATE] she knew she had many articles of cloths, toiletries, cell phone, C-Pap machine, upper and lower dentures. The daughter stated that when she got to the facility on [DATE] to pick her up, she and her aunt packed up her belonging. She said that out of the items they brought in on her admission only a dress and one bra were left. She said part of the C-pap machine, her cell phone and dentures were missing. The daughter said that she reported the missing items to the staff as she was trying to find the items to pack for discharge. The daughter said the clothing and toiletries are one thing, but it was terrible they lost the phone, dentures and parts of the C-Pap machine. The daughter stated that it was very hard to get a hold of her mom and she found out after calling several times that her mom had lost her phone and the facility staff could not find it. She said that she called the social worker several times and left messages, but she never returned those calls. She said the social worker never called her about the missing clothes, dentures, or phone.</p> <p>During an interview on 6/20/24 at 12:25 p.m., the Interim Director of Nursing (DON) verified the resident did lose her cell phone.</p> <p>She reported the daughter notified staff when she called the nurses station saying she could not get a hold of her mother for a couple of days.</p> <p>The DON said the staff looked for the cell phone and could not find it.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The DON stated that she felt that the resident most likely took it to the emergency room a few days before when the resident had called 911.</p> <p>The DON stated that she had worked in the emergency room and the phone most likely got wrapped up in sheets and sent to the laundry at the hospital and it was lost.</p> <p>The DON reviewed the resident Inventory of Personal Effects that was filled out on admission. The DON confirmed that the form was not filled out with what was present on discharge and was not signed by staff or responsible party.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 25618</p> <p>Based on record review, resident and staff interview, the facility failed to provide evidence a care plan conference was conducted with the resident and/or resident representative after completion of the comprehensive admission Minimum Data Set (MDS) assessment for 2 (Resident #13 and #54) of 4 residents reviewed. This did not allow the resident and/ or representative to participate in decision making related to the plan of care.</p> <p>The findings included:</p> <p>Review of the Care Planning - Interdisciplinary Team (IDT) policy with a revised date of September 2013 stated the facility is responsible for the development of an individualized comprehensive plan for each resident. The policy interpretation and implementation stated, 1. A comprehensive care plan for each resident is developed within seven (7) days of completion of the resident assessment (MDS) [Minimum Data Set] [sic] .3. The resident, the resident's family and/or the resident's legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan. 4. Every effort will be made to schedule care plan meetings at the best time of the day for the resident and family. [sic]</p> <p>1. On 6/17/24 at 11:36 a.m., in an interview with Resident #21 and Resident #21's granddaughter, they said since Resident #21's admission to the facility on [DATE] they had requested several times if Resident #21 and her family could have a plan of care meeting with the facility staff. Resident #21's granddaughter said due to her grandmother's confusion at times, the family requested to attend the plan of care meeting with the facility staff to ensure Resident #21 received the care and services she needed for a successful discharge home from the facility.</p> <p>Review of Resident #21's medical record revealed Resident #21 was admitted to the facility on [DATE]. Resident #21's Admission MDS assessment was completed and signed on 5/16/24. A progress note dated 5/08/24 by the Social Service Director (SSD) said the IDT meeting was held by the IDT to provide welcome and orientation to the facility for Resident #21 and to orient Resident #21 to the facility routines. The IDT would continue to monitor and provide updates and recommendations for Resident #21's transition to home. The progress note did not indicate Resident #21, nor her family attended the IDT meeting on 5/8/24.</p> <p>Further review of Resident #21's medical record revealed no documentation which facility staff had attended the IDT meeting on 5/08/24 and no documentation the facility had asked or encouraged Resident #21's family to attend the plan of care meeting with the IDT held on 5/08/24 as required per the facility's Care Planning - Interdisciplinary Team policy.</p> <p>A Baseline Care Plan summary form was signed by Resident #21 on 5/09/24 and co-signed by a floor nurse, the day after the IDT meeting.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/19/24 at 8:50 a.m., during an interview with the MDS Coordinator, after reviewing Resident #21's medical record, she confirmed Resident #21 was admitted to the facility on [DATE]. She said Resident #21's MDS assessment was completed and signed on 5/16/24 and Resident #21's comprehensive care plan was completed.</p> <p>The MDS Coordinator said after reviewing Resident #21's medical record, she was unable to find documentation which facility staff had attended Resident #21's IDT care plan meeting and/or if Resident #21 and/or her family was invited to the IDT care plan meeting.</p> <p>2. On 6/17/24 at 12:01 p.m., in an interview with Resident #13, he said since his admission to the facility on [DATE], he had not met with the facility's IDT to assist him in the determination of the appropriate treatment options to ensure he was strong enough to take care of himself when he was discharged home from the facility.</p> <p>Review of Resident #13's medical record revealed he was admitted to the facility on [DATE] and Resident #13's Admission MDS assessment was completed and signed on 6/03/24. Further review of Resident #13's medical record revealed no documentation the facility had invited Resident #13 and/or his representative to attend a plan of care meeting with the IDT and/or encouraged Resident #13 to participate in the development and decision making related to his plan of care while he was at the facility.</p> <p>The MDS Coordinator confirmed after reviewing Resident #13's medical record he was admitted to the facility on [DATE]. She said Resident #13's MDS assessment was completed and signed on 6/03/24 and Resident #13's comprehensive care plan was completed.</p> <p>The MDS Coordinator said she was unable to find documentation the facilities IDT had met with Resident #13 and/or encouraged him to participate in the creation and development of his comprehensive care plan as required in the Care Plan - Interdisciplinary Team policy. The MDS Coordinator said the nursing department was responsible for inviting the residents, and/or their family to the IDT comprehensive care plan meeting.</p> <p>On 6/19/24 at 10:37 a.m., in an interview with the Director of Nursing (DON), she said the nursing department was responsible for inviting the Resident and/or their family/representative to the comprehensive care plan meeting with the IDT and encourage them to participate in the development of and revisions of the resident's care plan.</p> <p>The DON reviewed Resident #21 and #13's medical record and said she was unable to find documentation the facility had encouraged Resident #21 and #13 and their family/representative to their comprehensive care plan meeting with the IDT (which included, but was not limited to the resident's attending physician, Dietary Manager/Dietician, Social Services Worker, Activity Director, Therapists and Director of Nursing) to encourage participation in the development of and revision to the resident's comprehensive care plan as required in the Care Planning - Interdisciplinary Team policy.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155</b></p> <p>Based on observation, review of facility policy and procedure, clinical record review, and resident and staff interview the facility failed to provide the necessary care and services to maintain personal hygiene for 7 (Resident # 6, #21, #32, #47, #53, #15 and #40) of 7 residents reviewed for activities of daily living (ADL).</p> <p>The findings included:</p> <p>The facility policy Activities of Daily Living (ADL's), Supporting, documented Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Appropriate care and services will be provided for residents who are unable to carry out ADL's independently, with the consent of the resident and in accordance with the plan of care.</p> <p>Review of the facility's Bath, Shower/Tub policy ,with revision date of February 2018, stated, The purpose of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin. [sic] In the Documentation section it stated the facility staff are required document the following: 1. The date and time the shower/tub bath was performed; 2. The name and title of the individual(s) who assisted the resident with the shower/tub bath; 3. All assessment data obtained during the shower/tub bath; 4. How the resident tolerated the shower/tub bath; 5. If the resident refused the shower/tub bath, the reason(s) why and the intervention taken; and 6. The signature and title of the person recording the data.</p> <p>1. Review of the clinical record revealed Resident #6 had an admitted [DATE] with diagnoses including hemiplegia and hemiparesis affecting the left side and muscle weakness.</p> <p>The Admission Minimum Data Set (MDS) (standardized assessment tool that measures health status in nursing home residents) with an assessment reference date of 4/16/24 documented Resident #6 required moderate assistance with dressing and bathing.</p> <p>The MDS noted Resident #6's cognitive skills for daily decision making were intact.</p> <p>On 6/17/24 at 1:54 p.m., in an interview Resident #6 said she did not get showers, they wash me in bed. I don't know why; a shower would be nice.</p> <p>On 6/19/24 at 10:10 a.m., Resident #6 was observed in her room in bed dressed in a hospital gown. Resident #6 asked if someone was coming to get her up, washed and dressed today. She said I need to get washed and I want to get up. Resident # 6 said she had not received a shower in some time, I don't remember when.</p> <p>Review of the Certified Nursing Assistant (CNA) task list revealed Resident #6 was scheduled for showers on Tuesday and Friday on the 7 a.m., to 3 p.m., shift. Review of the CNA charting from 5/21/24 through 6/18/24 showed Resident #6 received no scheduled showers. The documentation revealed Resident #6 received a bed bath on 5/21/24, 5/24/24, 5/28/24, 5/31/24, 6/4/24, 6/7/24, 6/11/24, 6/14/24 and 5/18/24. There was no documentation that the resident declined her scheduled showers.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. Review of the clinical record revealed Resident #32 had an admitted [DATE] with diagnoses including muscle weakness and need for assistance with personal care.</p> <p>The Admission MDS dated [DATE] documented the resident required moderate assistance with dressing and was dependent on staff for bathing. The MDS noted Resident #32's cognitive skills for daily decision making were moderately impaired.</p> <p>Review of the care plan initiated 5/21/24 identified the resident had a selfcare deficit with dressing, grooming and bathing. The goal for Resident #32 specified the resident will have a clean, neat appearance daily.</p> <p>On 6/17/24 at 10:31 a.m., in an interview Resident #32 said she does not always get her scheduled showers and does not get help to get out of bed. The resident was observed dressed in a hospital gown and her appearance was unkempt.</p> <p>On 6/18/24 at 9:52 a.m., in an interview and observation Resident #32 was in bed dressed in a hospital gown, her hair uncombed and she was disheveled. The resident said she was scheduled to get a shower today.</p> <p>A review of the facility grievance log revealed on 5/31/24 Resident #32's family member filed a grievance due to concerns with the resident's showers and requested a copy of the shower schedule.</p> <p>Review of the CNA documentation from 5/20/24 through 6/17/24 revealed Resident #32 received a scheduled shower on 5/31/24, 6/8/24 and 6/14/24.</p> <p>3. Review of the clinical record revealed Resident #47 had an admitted [DATE] with diagnoses including dementia, chronic pulmonary edema and chronic kidney disease.</p> <p>The Significant Change MDS dated [DATE] documented the resident required moderate assistance with dressing and was dependent on staff for bathing. The MDS noted Resident #47's cognitive skills for daily decision making were moderately impaired</p> <p>On 6/17/24 at 10:19 a.m., Resident #47 was observed in her bed in a hospital gown. The resident said she was supposed to receive two showers a week but usually only receives one. The resident said her hospice aid gives me a bath in the bed once a week, not a shower. There is a shower in my room. The staff tell me they are short staffed, but that is not my problem.</p> <p>On 6/17/24 at 1:18 p.m., in an interview Resident #47's family member said my mother needs to be bathed and not just washed in a bed. They don't answer the call lights here and do not provide the care needed.</p> <p>On 6/18/24 at 2:50 p.m., in an interview the Hospice aide said he comes twice a week to see Resident #47 and will do nail care, wash her face and hands, and take her outside. I don't do the showers; the facility staff are supposed to do that. I can do other things she wants to do, I read to her and we talk.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Village Place Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2370 Harbor Blvd Port Charlotte, FL 33952	
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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the CNA documentation revealed Resident #47's scheduled showers were on Thursday and Sundays on the 7 a.m., to 3 p.m., shift.</p> <p>The CNA documentation from 5/19/24 through 6/16/24 revealed the resident received a scheduled shower on 6/13/24 and no bed baths.</p> <p>4. Review of the clinical record revealed Resident #53 had an admitted [DATE] with diagnoses including muscle weakness, need for assistance with personal care, anxiety disorder and major depressive disorder.</p> <p>The Admission MDS dated [DATE] documented the resident required maximum assistance with dressing and bathing. The MDS noted Resident #53's cognitive skills for daily decision making were intact.</p> <p>Review of the care plan for Resident #53 documented the resident had a selfcare deficit with dressing, grooming and bathing due to generalized weakness.</p> <p>On 6/17/24 at 9:58 a.m., during an observation Resident #53 was in her bed and appeared unkempt. She said she has not received showers and she did not know why. Resident #53 said the staff were supposed to shower her today.</p> <p>On 6/18/24 at 8:56 a.m., Resident #53 was observed in bed, she said she had not received a shower but was told she would have one today. There was a shower located in the bathroom of the room.</p> <p>Review of the CNA task list documented the residents' showers were scheduled on Wednesday and Saturdays on the 3 p.m., to 11 p.m., shift.</p> <p>Review of the CNA documentation from 5/22/24 through 6/15/24 revealed Resident #53 received none of her scheduled showers.</p> <p>On 6/19/24 at 8:41 a.m., in an interview the Director of Nursing (DON) said the showers are listed on the CNA task list and the staff follow what is documented on the task list.</p> <p>On 6/19/24 at 9:01 a.m., in an interview Registered Nurse Staff C said the CNA's follow the shower schedule on the CNA task list. It provides the shower day and the shift it is to be done. Once it is complete the CNA brings the skin and shower form to the nurse if they find any abnormalities. If a resident refuses to be showered, then the nurse will attempt to speak with the resident and encourage them to accept a shower. If the resident continues to refuse, the CNA marks it on the shower form and the nurse and CNA sign it.</p> <p>On 6/19/24 at 9:15 a.m., in an interview CNA staff B said the resident's showers were located on a shower sheet at the nurse's desk and in the CNA task list. It tells us the shower day and the shift and if the resident prefers a shower or a bed bath. If a resident refuses, then we notify the nurse, and she will try and talk with the resident for us. If they still refuse, I report it to the nurse and document it on the CNA shower sheet.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 6/19/24 at 11:30 in an interview CNA Staff A said for showers, I come in for my shift and look at the shower book for the day's showers. I ask the residents when they want a shower, before or after breakfast or later in the day. When I complete the shower, I chart it in the computer and on the shower sheets. Most residents prefer showers, some refuse. We can give bed baths when they refuse but I only have one resident on this unit who refuses. We have a Hoyer lift and a shower chair so we can transfer residents to the chair and give the shower. If the resident continues to refuse, I let the nurse know.</p> <p>On 6/19/24 at 2:32 p.m., in an interview the DON said the staff were not required to complete the daily shower form unless something abnormal observed with the resident's skin. The DON confirmed the CNA documentation showed Resident #6, #47, #32 and #53 did not receive all showers as scheduled.</p> <p>25618</p> <p>5. On 6/17/24 at 11:41 a.m., in an interview with Resident #21 and Resident #21's granddaughter, they said since Resident #21's admission to the facility on [DATE] the facility staff did not give Resident #21 her scheduled showers as asked. Resident #21's granddaughter said due to her grandmother being incontinent of urine, the family had requested for Resident #21 receive a shower at least 2 times a week but the requested showers were not being completed as requested by Resident #21 and/or the family.</p> <p>On 6/19/24 at 1:37 p.m., in an interview with Staff H, a Certified Nursing Assistant (CNA), she said she had taken care of Resident #21 multiple times since Resident #21's admission to the facility. She said Resident #21's shower days were on Wednesday and Saturday. She said if a resident refused their shower or bed bath, they were required to ask them again if they could give them their shower/bed bath, if the resident still refused their shower, they were required to tell the resident's nurse and document the resident refusal of their shower on the Skin Monitoring: comprehensive CNA Shower Review form and give the form to the nurse. She said Resident #21 was very pleasant and she had not heard that Resident #21 had refused care and/or her showers.</p> <p>Review of Resident #21's medical record revealed she was admitted to the facility on [DATE]. Resident #21's medical record revealed Resident #21's shower days were scheduled for every Wednesday and Saturday during the day shift.</p> <p>Review of the documentation on the ADL sheets for Resident #21 revealed Resident #21 had a bed bath on 5/5, 5/6, 5/13 and 5/15. There was no documentation Resident #21 received a shower during the month of May 2024. Review of the ADL sheets for Resident #21 for the month of June 2024 revealed she had received a shower on 6/6 and 6/14. Review of Resident #21's ADL documentation revealed she had 0 showers out of a possible 7 showers during May 2024 and 2 showers out of a possible 6 showers in June 2024 since being admitted to the facility on [DATE]. Further review of Resident #21's medical record that included ADL sheets and progress notes, revealed no documentation Resident #21 had refused her scheduled showers and/or documentation of the intervention facility staff had taken to encourage Resident #21 to receive her scheduled showers. There were no Skin Monitoring: comprehensive CNA Shower Review forms in the medical record for Resident #21.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 6/16/24 at 4:00 p.m., in an interview with the Director of Nursing (DON), she said the facility staff were required to assist each resident with their showers/baths as scheduled each week. If a resident refused their shower/bath, the CNAs were required to make a second attempt and if the resident still refused their shower/bath, the CNAs were to inform the resident's nurse and document the resident refusing their shower/bath on the Skin Monitoring: comprehensive CNA Shower Review form and give the form to the resident's nurse. The DON said the nurse was required to document in the resident's medical record if the resident continued to refuse their shower/bath and the intervention(s) used to encourage the resident to take their shower/bed bath.</p> <p>The DON reviewed Resident #21's medical record and confirmed Resident #21 was admitted to the facility on [DATE]. The DON confirmed Resident #21 had a bed bath on 5/5, 5/6, 5/13 and 5/15 and a shower on 6/6 and 6/14. The DON also confirmed Resident #21 had 2 showers out of a possible 13 showers since being admitted to the facility on [DATE]. The DON said she was unable to find documentation that Resident #21 had refused her shower on her scheduled shower days and the interventions the facility staff had attempted to encourage Resident #21 to take her showers as required per the facility policy.</p> <p>49527</p> <p>6. Review of the clinical record for Resident #15 revealed an admitted [DATE] with diagnoses of hemiplegia (one sided paralysis) and hemiparesis (one sided weakness) following a cerebral infarction (stroke) that affected the left side, and contractures.</p> <p>The Quarterly Minimum Data Set (MDS) assessment with a target date of 5/15/24 noted Resident #15's cognition was moderately impaired with a Brief Interview for Mental Status score of 8. Resident #15 required substantial/maximal assistance (helper does more than half the effort) from staff for personal hygiene care.</p> <p>On 6/17/24 at 9:53 a.m., Resident #15 was observed without a palm protector on her left-hand contracture (hardening of muscle, tendon, and tissue).</p> <p>On 6/18/24 at 8:54 a.m., Resident #15 observed without a palm protector on her left hand contracture.</p> <p>On 6/20/24 at 8:41 a.m., in an interview with Resident #15's son in law said he never sees the palm protector on her when he visits. The family member opened her hand, and her fingernails were extending 1/2 inch past her fingertips.</p> <p>The observation of Resident #15's palm on her left hand had two fingernail marks in the palm that did not disappear when relieved of pressure, from the fingernail of her ring finger.</p> <p>On 6/20/24 at 9:05 a.m., CNA Staff A observed and verified Resident #15's nails extended 1/2 inch past the fingertips.</p> <p>On 6/20/24 at 9:22 a.m., in an interview the DON confirmed the fingernail marks in Resident #15's left palm. She said the resident's nails needed to be cut. Her expectation is the CNA should be noticing when nails need to be done.</p> <p>(continued on next page)</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>7. Review of the clinical record for Resident #40 revealed an admitted [DATE] with diagnoses of hemiplegia (one sided paralysis) and hemiparesis (one sided weakness) following a cerebral infarction that affected the left side.</p> <p>The Admission Minimum Data Set (MDS) assessment with a target date of 3/15/24 noted Resident #40's cognition was moderately impaired with a Brief Interview for Mental Status score of 12. Resident #40 required dependent (helper does all the effort. Resident does none of the effort to complete activity) for her personal hygiene care.</p> <p>On 6/18/24 at 9:21 a.m., in an interview Resident #40 said staff tried to open her hand this morning. She said they do not wash her hand or help her clean her nails. The resident's nails were extending approximately 1/8 inch past the tip of her fingers.</p> <p>On 6/19/24 at 9:44 a.m., in an interview Licensed Practical Nurse (LPN) Staff M verified the resident's fingernails extended approximately 1/8 inch past the fingertips and needed to be trimmed.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155</b></p> <p>Based on observation, review of facility policy and procedure, record review and staff and resident interview, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for 3 (Resident #6, #47, and #423) of 6 residents reviewed with physician ordered treatments and positioning devices.</p> <p>The findings included:</p> <p>The facility policy Medication and Treatment Orders (revised 7/16) documented Orders for medications and treatments will be consistent with principles of safe and effective order writing.</p> <p>1. Review of the clinical record revealed Resident #6 had an admitted [DATE] with diagnoses including hemiplegia and hemiparesis affecting the left side, iron deficiency anemia and muscle weakness.</p> <p>The Admission Minimum Data Set (MDS) (standardized assessment tool that measures health status in nursing home residents) with an assessment reference date of 4/16/24 documented Resident #6 required moderate assistance with dressing and bathing.</p> <p>The MDS noted Resident #6's cognitive skills for daily decision making were intact.</p> <p>On 6/17/24 at 1:54 p.m., during an interview and observation, Resident # 6 said she had wounds on her lower left leg and pulled her pant leg up to show a dressing on her outer left leg. Resident #6 said it was a skin tear and she had three of them on her leg. Resident #6 was observed to have bruises in different stages of healing on her hands and arms and said, I bruise so easy.</p> <p>A review of the physician orders revealed an order dated 5/24/24 to Apply Geri sleeves to bilateral arms to protect skin from injury as resident tolerates. May remove for personal hygiene and bathing, every shift.</p> <p>Review of the nursing progress notes dated 6/16/24 and 6/17/24 revealed documentation that the nurses did not apply the Geri sleeves as ordered because they were not available and were waiting for delivery.</p> <p>Further review of the physician orders documented an order dated 6/7/24 for compression stockings (stockings used to decrease swelling in the feet and lower legs) to be applied in the morning and removed in the evening.</p> <p>Review of the nursing progress note dated 6/13/24 documented the compression stockings were not applied as they were unavailable.</p> <p>On 6/18/24 at 9:10 a.m., Resident #6 was observed in her room in bed. She was noted to have multiple bruises on both of her arms. She said I don't know what it is, but I bruise so easily. They are looking much better now. She said she had not had long gloves (Geri-sleeves) applied ever. There were no compression stockings on her lower legs, and she said she did not know anything about the stockings.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 6/18/24 at 11:38 a.m., Resident #6 was observed in bed without the Geri-sleeves on. She was rubbing her arms and hands looking at the bruises on her skin. The resident did not have compression stockings on. Resident #6 said they did not put the stockings or the sleeves on her today. The resident was noted to have swelling in her feet and ankles.</p> <p>On 6/18/24 at 2:38 p.m., in an interview Licensed Practical Nurse Staff E said she was aware Resident #6 did not have the Geri sleeves and the compression stockings on as ordered by the physician. Staff E said she had searched the resident's room and was not able to locate the Geri sleeves or the stockings and would go to the central supply room and obtain the items. Staff E returned with a pair of Geri sleeves and said there were no compression stockings in the supply room, and they are on order. Staff E applied the Geri sleeves to Resident #6's arms.</p> <p>Further review of Resident #6's clinical record failed to show documentation that the physician or his representative was notified the Geri sleeves and compression stockings' were not available and not applied as ordered.</p> <p>2. Review of the clinical record revealed Resident #47 had an admitted [DATE] with diagnoses including type 2 diabetes, peripheral vascular disease and pressure ulcer to right heel.</p> <p>The Admission MDS with an assessment reference date of 4/2/24 documented Resident #47 required substantial to maximum assistance with bed mobility including turning side to side. The MDS noted the resident was at risk for pressure wounds and was admitted with a pressure wound on the right heel.</p> <p>The MDS noted Resident #47's cognitive skills for daily decision making were moderately impaired.</p> <p>The clinical record revealed a physician order dated 4/2/24 that specified Padded boots to bilateral feet while in bed every shift.</p> <p>On 6/17/24 at 10:19 a.m., Resident #47 was observed in her bed without the padded boots on and no other positioning devices to off load the pressure to the heels.</p> <p>On 6/17/24 at 1:18 p.m., in an interview Resident #47's family member said her mother needs to be bathed and not just washed in a bed. She said they don't answer the call lights here and do not provide the care needed. I have never seen any padded boots on her feet, and I can tell you they are not in this room. I know everything she has in here.</p> <p>On 6/18/24 at 9:17 a.m., Resident #47 was observed in her bed without the padded boots on her feet.</p> <p>On 6/18/24 at 2:38 p.m., in an interview Licensed Practical Nurse Staff E said Resident #47 has not had the padded boots on because central supply needed to order them. We do not have them. I know she has the order for the boots, but I have looked and there are not any in the room. I did speak with central supply, and they have been ordered.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 6/18/24 at 3:13 p.m., in an interview the Central Supply Manager Staff F said when supplies are needed the nurse will come and let me know and there is also a sheet on the back of my door if anything is ordered when I'm not here. Staff F said, I know Resident #6 needed the Geri sleeves and compression stockings and I ordered them. Staff F said she had placed an order for the padded heel boots for Resident #47. Staff F said I ordered the supplies Monday 6/17/24 and they should be here on Friday. She said she must get approval from management before she places the supply orders.</p> <p>On 6/19/24 at 1:40 p.m., in an interview the Regional Nurse Consultant, said the facility had no policy for following physician orders.</p> <p>On 6/19/24 at 2:14 p.m., in an interview Certified Nursing Assistant Staff G said Resident #47 had a sore on her right heel but it was now healed.</p> <p>On 6/19/24 at 2:43 p.m., in an interview the Director of Nursing said the expectation for resident ordered treatment supplies would be 3 days and if not available the nurse was to contact the physician.</p> <p>On 6/19/24 at 12:33 p.m., in an interview with Resident #6 and #47's Physician said he was not informed the padded heel boots for pressure wound prevention were not applied and not available for Resident #47. The Physician said he was not made aware the Geri sleeves and the compression stockings ordered for Resident #6 were not applied as ordered. The Physician said, I have different associates who see my residents at the facility, but I will check on it.</p> <p>38570</p> <p>3. On 6/17/24 at 12:03 p.m., Resident #423 was observed laying in her bed on her back. She was dressed in a pair of capri pants and a top. All areas of the resident's skin that was observed was covered with a slightly raised red prickly rash. The rash varied in degree with areas appearing to have bumps thick and touching each other and areas the bumps were spread apart. On the resident's back the rash started high on her shoulder blades and the right side was much more inflamed with larger bumps that almost ran together in some spots. Some of the rash appeared to have pimply tops on them. The Resident's lower legs had the same rash but not as intense and close together. The full length of her right arm had the raised rash, and it was on both sides of her hand and between her fingers. The palms of her hands looked crusty and peeling. The Resident's stomach was also covered with the rash from under her breast spreading to her groin area.</p> <p>During an interview on 6/17/24 at 12:03 p.m., Resident #423's spouse said that when his wife was first admitted on [DATE] she just had a rash on her back but now it is all over her body. The husband report that he comes every day to visit, and it is getting so much worse. He said he has asked the staff multiple times for a dermatologist consultation. So far nothing has been done and his wife is itching all the time and constantly moving and itching and rubbing. The husband said he has asked at least twice to have her seen by a dermatologist. He said she really does not talk much but he can see it is bothering her.</p> <p>During the 20-minute interview with the resident's husband the resident was observed and never stopped itching. She was itching her stomach, under her waist band, her arms and hands, her neck and reaching for her lower leg.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The husband gave permission to take photographic evidence pictures of her back (2 views) her stomach, right arm and hand and lower legs.</p> <p>During an interview on 6/18/24 at 4:30 p.m., Resident #423's husband said that the rash was still all over his wife's body even though they have been treating it. It seems like it is only getting worse, and he hope that someone will help his wife.</p> <p>A review of an Admission Record indicated the facility admitted Resident #423 on 5/2/24 with the following diagnosis: Sepsis, Clostridium Difficile (C-diff) and infectious diarrhea, muscle weakness, depression, Alzheimer's disease, hypertension, heart failure, chronic obstructive pulmonary disease (COPD) and history of urinary tract infection.</p> <p>The admission Minimum Data Set (MDS) dated [DATE]revealed Resident #423 had a Brief Interview for Mental Status (BIMS) score of 00 resident was unable to complete the interview due to being severely cognitively impaired. Functional abilities on admission were substantial assistance with all acts of daily living (ADLs). Resident is frequently incontinent of urine and always incontinent of bowel. Under skin conditions there is no way to indicate if resident had a full body rash.</p> <p>Review of Resident #423's Care Plans initiated 5/8/24 indicated that resident had decreases social interaction r/t cognitive impairment. Resident is a short stay placement and lives in a memory care assisted living facility. Resident was not care planned to address the full body rash and treatment ordered for it. No monitoring of the rash in the care plan.</p> <p>On review of Resident #423 skin assessments and notes are as follows:</p> <p>5/2/24 admission assessment - full body rash with excoriation to peri and buttock</p> <p>5/3/24 weekly skin check - full body rash</p> <p>5/3/24 wound evaluation - groin rash - treatment - zinc paste open to air</p> <p>5/9/24 weekly skin check - no notation of body rash</p> <p>5/10/24 wound evaluation - groin rash - getting larger Dermatology consult requested for rash (no dermatology consult since admission)</p> <p>5/17/24 wound evaluation - groin rash - resolved BSRN</p> <p>5/21/24 weekly skin check - no indication or notation of body rash</p> <p>5/28/24 Weekly skin check - no indication or notation of body rash</p> <p>6/5/24 Weekly skin check - no indication or notation of body rash</p> <p>6/7/24 -13:51 Spouse concerned that rash is worsening, seen by wound care (WC) this shift (no note in the record). Added hydrocortisone cream, has hydroxyzine order in place and dermatology consult faxed to dermatology office per instructions. written by nursing supervisor (no dermatology consult since admission)</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>6/18/24 Weekly skin check - no indication or notation of body rash</p> <p>On review of all Physician and/or Nurse Practitioner (NP) progress notes of skin rash according to date:</p> <p>On 5/17/24 the last wound care note for full body rash written by wound care NP. (rash documented as being resolved at this visit)</p> <p>On 5/29/24 a Medical Directors note indicated a generalized, splotchy, pruritic rash covering more than half of body surface. Candida Rash: will continue miconazole for now.</p> <p>During an interview on 6/19/24 at 10:02 a.m., CNA Staff H said that she feels that the resident's rash on admission was bad, but now it is better in her groin area but not the rest of her body. CNA said the resident is still itching all the time.</p> <p>During an interview on 6/19/24 at 10:24 a.m. LPN staff I said she knows the resident has a rash and she has been being treated since admission. The nurse reports that the doctor thinks it is a fungal rash but states it does not seem to be getting better. The nurse said that she did get admitted with a bad rash in her groin area for the C-diff but that has cleared up almost completely. The nurse states that she knows that there has been a dermatology consult faxed but no one has come so far.</p> <p>During an interview on 6/19/24 at 10:50 a.m., Interim Director of Nursing (DON) said she is aware of the resident, and she came in with a rash. DON said the nurses should be documenting on resident skin condition and notifying practitioner if treatment is improving her skin condition or not.</p> <p>During an interview on 6/19/24 at 12:37 p.m. the Medical Director said that he looked at Resident #423's body rash and it is definitely not scabies. He said that multiple staff members have taken care of the resident, and no one has come up with any scabies, so he does not feel it is scabies. He said that he is going to call and have an infectious disease doctor come over and see what he thinks it is. The Medical Director said that the hospital was treating the resident rash as a fungal rash, and he felt it did look like it on admission but now he feels that it has a different look to it. The rash is not so much like a fungal rash and now it looks like an allergic reaction of some sort, maybe to a dye in a medication.</p> <p>During an interview on 6/20/24 at 3:23 p.m., the Administrator said that the infectious disease doctor had come in and looked and Resident #423's rash and said he would have to biopsy it to be sure of what it is.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49527</p> <p>Based on observation, record review, review of facility's policies and procedures, and resident and staff interviews, the facility failed to prevent the development or worsening of pressure ulcers for 2 (Residents #40 and #47) of 3 residents reviewed for pressure injuries.</p> <p>The findings included:</p> <p>The facility policy titled Repositioning revised May 2013, showed the purpose of this procedure is to provide guidelines for the evaluation of resident repositioning needs, to aid in the development of an individualized care plan for repositioning, to promote comfort for all bed or chair-bound residents and to prevent skin breakdown, promote circulation and provide pressure relief for residents.</p> <p>General Guidelines</p> <ol style="list-style-type: none"> <li>1. Repositioning is a common, effective intervention for preventing skin breakdown, promoting circulation, and providing pressure relief .</li> <li>3. Repositioning is critical for a resident who is immobile or dependent upon staff for repositioning .</li> <li>5. Positioning the resident on an existing pressure ulcer should be avoided since it puts additional pressure on tissue that is already compromised and may impede healing .</li> </ol> <p>Interventions</p> <ol style="list-style-type: none"> <li>4. Residents with a Stage I or above pressure ulcer, every 2-hour repositioning schedule is inadequate.</li> <li>1. Review of the clinical record for Resident #40 revealed an admitted [DATE] with diagnoses of hemiplegia (one sided paralysis) and hemiparesis (one sided weakness) following a cerebral infarction that affected the left side.</li> </ol> <p>The Admission Minimum Data Set (MDS) assessment with a target date of 3/15/24 noted Resident #40's cognition is moderately impaired with a Brief Interview for Mental Status score of 12.</p> <p>The resident had one unstageable pressure ulcer on admission. The MDS noted a pressure reducing device for bed and chair, pressure ulcer care, surgical wound care, and applications of ointments/medication other than feet.</p> <p>The MDS with a target date of 4/8/24 showed Resident #40 needed substantial/maximal assistance to roll left and right.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a wound care assessment by the provider dated 6/14/2024, noted The patient has a pressure injury. Recommend ongoing pressure reduction and turning/repositioning precautions per protocol, including pressure reduction to the heels and all bony prominences. All prevention measures were discussed with the staff at the time of the visit. Continue with turning and repositioning schedule per protocol for pressure prevention. Position patient side to side as tolerated. The patient continues an alternating air/low air loss mattress for pressure redistribution. Ensure settings are maintained at an appropriate level based on the patient's needs and body habits.</p> <p>Review of the care plan for Resident #40 initiated 3/28/24 and revised on 6/6/24 showed pressure ulcer. Intervention to turn and reposition to promote offload pressure.</p> <p>On 6/17/24 at 9:40 a.m. observed Resident #40 lying on her back. The resident said she has a sore on her back. She said it hurts to lay on it.</p> <p>On 6/18/24 at 9:17 a.m., observed, Resident #40 in bed. The resident is on an air mattress (pressure redistribution therapy) with pump, set for 150 lbs. The Resident's weight on 6/12/2024 was 97.6 pounds. The manufacturers instruction for the air mattress pump showed to determine the patient's weight and set the control knob to that weight setting on the control unit. Resident #40 is on her back with head of bed elevated about 20-30 degrees with knees bent. A pillow was on the right side of her body. The resident said it is not under her bottom. The resident said last night the staff moved it to the left side. She said staff only come in and reposition her maybe 2 times a day.</p> <p>Photographic Evidence Obtained</p> <p>On 6/18/24 at 10:32 a.m., in an interview Resident #40 said no one has come in to turn her. Observed resident in bed with the air mattress pump was set at 150 lbs. The resident was observed on her back with HOB elevated about 20-30 degrees with the knees bent. The pillow is on her right side. The resident stated, it's still not under me.</p> <p>On 6/18/24 at 2:38 p.m., observed Resident #40 in bed with a pillow under her left arm.</p> <p>On 6/18/24 at 3:53 p.m., observed Resident #40 repositioned with pillow under her right side.</p> <p>On 6/19/24 at 9:44 a.m., an interview with Licensed Practical Nurse (LPN) Staff M said maintenance places the air mattress on the bed and sets the pump settings. She does not turn the settings. LPN Staff M stated we don't touch them. LPN Staff M showed Resident #40's feet. She said both heels are soft, boggy and red. LPN Staff M verified heels are flat on the bed and not elevated on a pillow. They should be offloaded.</p> <p>On 6/19/24 at 2:13 p.m., an interview with LPN Staff K, Unit Manager, said nurses monitor if the air mattress is inflated or not. The company sets up the bed with the settings. The setting is set per manufacturers guidelines.</p> <p>On 6/19/24 at 4:48 p.m., observed Resident #40 on her back with the air mattress pump set at 150 lbs. Resident did not have a pillow under either side of her body.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/20/24 at 1:00 p.m., during an interview with DON, she verified Resident #40s heels should be offloaded. DON verified heel areas on both feet were soft, and redness was present on the heels and the right ankle bone. DON verified with Resident #40 that she would like her heels floated off the mattress and turned on her side because her bottom hurts.</p> <p>On 6/20/24 at 2:15 p.m., an interview with RN Staff AA, Wound Care Nurse, said Resident #40's right heel looks like a 2 to 3 cm area of redness with a fluid substance in the center is roughly 2 cm area.</p> <p>On 6/20/24 at 2:15 p.m., observed RN Wound Care Nurse Staff AA, completed pressure ulcer dressing change on Resident #40. She did not perform hand washing before starting, between glove change of contaminated dressing removal, or after completion of treatment.</p> <p>On 6/20/24 at 2:25 p.m., an interview with RN Staff AA verified she did not perform hand hygiene after removing old dressing or going to the cart to retrieve forgotten supplies. She stated, I knew I forgot something.</p> <p>41155</p> <p>2. Review of the clinical record revealed Resident #47 had an admitted [DATE] with diagnoses including type 2 diabetes, peripheral vascular disease and pressure ulcer to right heel.</p> <p>The Admission MDS with an assessment reference date of 4/2/24 documented Resident #47 required substantial to maximum assistance with bed mobility including turning side to side. The MDS noted the resident was at risk for pressure wounds and was admitted with a pressure wound on the right heel.</p> <p>The MDS noted Resident #47's cognitive skills for daily decision making were moderately impaired.</p> <p>The clinical record revealed a physician order dated 4/2/24 that specified Padded boots to bilateral feet while in bed every shift.</p> <p>On 6/17/24 at 10:19 a.m., Resident #47 was observed in her bed without the padded boots on and no other positioning devices to off load the pressure to the heels.</p> <p>On 6/17/24 at 1:18 p.m., in an interview Resident #47's family member said her mother needs to be bathed and not just washed in a bed. She said they don't answer the call lights here and do not provide the care needed. I have never seen any padded boots on her feet, and I can tell you they are not in this room. I know everything she has in here.</p> <p>On 6/18/24 at 9:17 a.m., Resident #47 was observed in her bed without the padded boots on her feet.</p> <p>On 6/18/24 at 2:38 p.m., in an interview Licensed Practical Nurse Staff E said Resident #47 has not had the padded boots on because central supply needed to order them. We do not have them. I know she has the order for the boots, but I have looked and there are not any in the room. I did speak with central supply, and they have been ordered.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/18/24 at 3:13 p.m., in an interview the Central Supply Manager Staff F said when supplies are needed the nurse will come and let me know and there is also a sheet on the back of my door if anything is ordered when I'm not here. Staff F said she had placed an order for the padded heel boots for Resident #47. Staff F said I ordered the supplies Monday 6/17/24 and they should be here on Friday. She said she must get approval from management before she places the supply orders.</p> <p>On 6/19/24 at 1:40 p.m., in an interview the Regional Nurse Consultant, said the facility had no policy for following physician orders.</p> <p>On 6/19/24 at 2:14 p.m., in an interview Certified Nursing Assistant Staff G said Resident #47 had a sore on her right heel but it was now healed.</p> <p>On 6/19/24 at 2:43 p.m., in an interview the Director of Nursing said the expectation for resident ordered treatment supplies would be 3 days and if not available the nurse was to contact the physician.</p> <p>On 6/19/24 at 12:33 p.m., in an interview with Resident #47's Physician said he was not informed the padded heel boots for pressure wound prevention were not applied and not available for Resident #47. The Physician said, I have different associates who see my residents at the facility, but I will check on it.</p>

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49527</b></p> <p>Based on observations, interviews, and record reviews, the facility failed to provide care and services to prevent a decline in range of motion for 3 (Residents #14, #15, and #40) of 3 sampled residents reviewed with limited range of motion.</p> <p>The findings included:</p> <p>Review of the facility's policy titled Resident Mobility and Range of Motion with a revision date of July 2017 showed, . 2. Residents with limited range of motion will receive treatment and services to increase and / or prevent a further decrease in range of motion (ROM). 3. Residents with limited mobility will receive appropriate services, equipment and assistance to maintain or improve mobility.</p> <p>1. Review of the clinical record for Resident #14 revealed an admitted [DATE] with diagnoses of hemiplegia (one sided paralysis) and hemiparesis (one sided weakness) following a cerebral infarction (stroke) that affected the right side.</p> <p>The Quarterly Minimum Data Set (MDS) assessment with a target date of 4/23/2024 noted Resident #14's cognition was moderately impaired with a Brief Interview for Mental Status score of 10. The resident's functional range of motion was impaired on one side of the upper and lower extremities.</p> <p>Review of the Occupational Therapy (OT) Discharge Summary, Resident #14 was discharged from OT on 4/16/24. The discharge report showed a soft resting hand splint was ordered, received, and adjusted for the resident. The progress note revealed the resident needs max assist (staff provide about 75% help) with placing of the splint.</p> <p>Recommendations from OT discharge showed prognosis to maintain CLOF (current level of function) is good with consistent staff follow-through and nursing to assist splint application.</p> <p>Review of the OT evaluation on 6/19/24 showed upper right extremity strength is 0/5 with impaired fine and gross motor coordination, and impaired sensation. OT's evaluation noted Resident #14 can benefit from the use of resting hand splints to preserve proper alignment and to protect against [NAME] skin integrity problems.</p> <p>The care plan initiated on 2/27/24, did not indicate any range of motion or hand splint care.</p> <p>On 6/17/24 10:02 a.m., observed Resident #14 in a wheelchair with right sided paralysis, with bruising to right forearm, and unsupported. The resident demonstrated how she moved her right arm with her leg. She did not have a splint on her right hand.</p> <p>On 6/18/24 at 8:47 a.m., observed Resident #14 without a hand splint on the right hand.</p> <p>On 6/18/24 at 2:49 p.m., observed Resident #14's right arm lying at side without a hand splint. Observed red blotchy marks on right outer forearm.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/19/24 at 9:15 a.m., observed Resident #14 without a hand splint on the right hand.</p> <p>On 6/20/24 at 9:22 a.m., an interview with Director of Nursing (DON) said she expected the nurses to ask questions if they see care is not being provided for a resident with range of mobility or contractures (hardening of muscles, tendons, and/or tissue).</p> <p>2. Review of the clinical record for Resident #15 revealed an admitted [DATE] with diagnoses of hemiplegia (one sided paralysis) and hemiparesis (one sided weakness) following a cerebral infarction that affected the left side, and contractures.</p> <p>The Quarterly Minimum Data Set (MDS) assessment with a target date of 5/15/24 noted Resident #15's cognition was moderately impaired with a Brief Interview for Mental Status score of 8.</p> <p>Resident #15 required substantial/maximal assistance of staff for upper body dressing and was dependent of staff on lower body dressing.</p> <p>Review of the care plan initiated on 3/12/24 showed a decreased range of motion related to generalized weakness and late effects of stroke. There is no intervention to prevent a decrease in range of motion or worsening contractures.</p> <p>On 6/17/24 at 9:53 a.m., observed Resident #15's left-hand contracture without a palm protector on the left hand.</p> <p>On 6/18/24 at 8:54 a.m., observed Resident #15's left-hand contracture without palm protector on the left hand.</p> <p>On 6/18/24 at 10:35 a.m., observed Resident #15 without a palm protector on the left hand.</p> <p>On 6/19/24 at 2:39 p.m., an interview with the Director of Rehabilitation said OT had worked with Resident #15 from 3/2/24 to 4/25/24. Director of Rehabilitation read the OT discharge summary notes and said the recommendation was left upper extremity passive range of motion (hand) and palm protector in place to prevent decline. He did not see an order for a left palm protector.</p> <p>On 6/20/24 at 8:41 a.m., an interview with Resident #15's son in law, who is a Certified Nurse Assistant (CNA) at a hospital, found Resident #15's left hand palm protector in the nightstand drawer. He said he never sees the palm protector on her when he visits. The family member opened the resident's hand, and her fingernails were a 1/2 inch past her fingertips. Resident #15's palm on her left hand had 2 fingernail marks cutting into the skin, that did not disappear when relieved of pressure, from the fingernail of her ring finger.</p> <p>On 6/20/24 08:59 a.m., an interview with CNA Staff A said she does not put a device on Resident #15's hand. She did not know the resident had a hand contracture.</p> <p>On 6/20/24 at 9:22 a.m., an interview with DON confirmed the two indentations on Resident #15's left hand. She stated yes, the nails need cut.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/20/24 at 9:53 a.m., an interview with DON said Resident #15 does not have an order for palm protector use. DON reviewed the OT notes that showed LUE PROM (hand) and 1 / LUE to prevent decline in same (palm protector in place). She said she will go talk to the Director of Rehabilitation about her palm protector.</p> <p>On 6/20/24 at 10:34 a.m., an interview with DON said she talked to Director of Rehabilitation about not having an order for Resident #15 for a left palm protector, and he said, I already told that lady (surveyor) this is something that needs to be fixed.</p> <p>Review of the clinical record for Resident #40 revealed an admitted [DATE] with diagnoses of hemiplegia (one sided paralysis) and hemiparesis (one sided weakness) following a cerebral infarction that affected the left side.</p> <p>The Admission Minimum Data Set (MDS) assessment with a target date of 3/15/24 noted Resident #40's cognition is moderately impaired with a Brief Interview for Mental Status score of 12.</p> <p>The resident functional range of motion was impaired one-sided of the upper and lower extremities. Resident #40 required substantial/maximal assistance of staff for upper body dressing and was dependent of staff on lower body dressing.</p> <p>Review of the physician's order summary showed an order for Left hand palm protector in place as tolerated due to fistled posture with skin integrity risk related to moisture and fingernails. PROM L (passive range of motion Left) elbow and finger extension during routine dressing / cleaning which was discontinued on 5/29/2024.</p> <p>The care plan initiated on 3/12/24 and revised on 6/6/24 noted Resident #40 showed a decreased range of motion related to generalized weakness and late effects of stroke. The interventions are only listed for therapy. There are no nursing or CNA interventions.</p> <p>Review of Occupational Therapy Discharge Summary for services from 4/13/24 to 5/10/24 showed resident #40 had a 45 % passive extension of digits and the tolerated rolled washcloth in left hand at time of discharge from OT. The resident's prognosis to maintain current level of function was good with consistent staff follow through. There were no orders for staff to place rolled washcloth in left hand.</p> <p>Review of OT services dated 5/23/24 and discharged on [DATE] showed Resident #40's interventions provided: emphasized finger extension and elbow extension with palm rolls (rolled washcloth) demonstrated for staff. Palm protector ordered. Nursing staff and CNAs performed application of palm roll / palm protector.</p> <p>On 6/17/24 at 9:40 a.m., observed Resident #40 with a left-hand contracture. No rolled cloth or palm protector on the left hand.</p> <p>On 6/17/24 at 2:42 p.m., an interview with Resident #40 said staff only puts a rolled washcloth in my hand occasionally.</p> <p>On 6/18/24 at 9:17 a.m., observed Resident #40 with no rolled cloth or palm protector on the left hand.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/18/24 at 2:38 p.m., observed Resident #40 without a rolled cloth or palm protector in left hand.</p> <p>On 6/19/24 at 8:12 a.m., observed Resident #40 without a palm protector or rolled washcloth in the left hand.</p> <p>On 6/19/24 at 9:44 a.m., an interview with LPN Staff M verified fingernails cutting into the base of Resident #40's thumb. LPN Staff M said no roll was placed in the resident hand.</p> <p>On 6/19/24 at 2:39 p.m., an interview with Director of Rehabilitation said when a splint is needed, OT will write an order for staff to follow.</p> <p>On 6/20/24 at 8:32 a.m., CNA Staff Z said she does not put a washcloth in her hand on a regular basis.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  106072	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/20/2024
NAME OF PROVIDER OR SUPPLIER  Village Place Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2370 Harbor Blvd Port Charlotte, FL 33952	
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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>49527</p> <p>Based on observations, interviews, and facility policy review, the facility failed to ensure a multi-resident use glucometer (device to check blood sugar levels), was properly disinfected, and/or standard precautions were followed during medication pass for 2 (Resident #9, and #56) of 5 residents reviewed for infection control.</p> <p>The findings included:</p> <p>Review of the facility policy titled Hand washing/Hand Hygiene revised August 2015, showed This facility considers hand hygiene the primary means to prevent the spread of infections. 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. 7. Use an alcohol-based hand rub (ABHR) . or alternatively, soap and water for the following situations: g. Before handling clean or soiled dressings, gauze pads, etc.; k. After handling used dressings, contaminated equipment, etc.; m. After removing gloves; .</p> <p>1. Perform hand hygiene before applying non-sterile gloves.</p> <p>Review of the facility policy titled Cleaning and Disinfection of Glucometer Machine undated, showed Glucometer machines will be cleaned and disinfected according to current CDC (Centers for Disease Control and Prevention) recommendations for disinfection and the OSHA (Occupational Safety and Health Administration) bloodborne pathogens standards.</p> <p>4) After the glucometer machine has been wiped and left wet, it will be wrapped with the bleach wipe towel for a total of 3 to 5 minutes depending on what the manufacturer's guidelines.</p> <p>On 6/19/24 at 8:27 a.m., Registered Nurse (RN) Staff Q was observed to wipe all sides of the glucometer with a disinfectant wipe and threw the wipe away. The glucometer was placed on a tissue on the medication cart, then placed in the upper right drawer of the cart. It did not remain visibly wet for the acquired length of time.</p> <p>On 6/19/24 at 9:15 a.m., during an interview RN Staff Q confirmed the glucometer is a multi-resident use device. She said she wipes the meter down and sets it on her cart to dry. She stated, I cannot tell you how long it was wet for. The glucometer must stay visibly wet for 1 minute per direction on the disinfecting wipes used by the facility.</p> <p>On 6/19/24 9:20 a.m., in an interview Licensed Practical Nurse (LPN) Unit Manager Staff I said we have to keep the glucometer wet for one to two minutes.</p> <p>On 6/19/24 at 8:14 a.m., observed medication administration for Resident #9 with LPN Staff M. She removed a total of six pills from the packaging into her ungloved hand, and placed each tablet in a medication cup.</p> <p>On 6/19/24 at 8:21 a.m., observed medication administration for Resident #56 with LPN Staff M. She removed three pills from the packaging into her ungloved hand, then placed each tablet into the medication cup.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Village Place Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2370 Harbor Blvd Port Charlotte, FL 33952	

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 6/19/24 at 8:26 a.m., in an interview LPN Staff M verified she placed the pills into her ungloved hands before administering them to the residents. She stated that is my process when asked if it was standard practice when she placed medication in her ungloved hand and then placed it in the medication cup.</p>