STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106075	A. Building B. Wing	12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden View Health and Rehabilitation Center	2180 10th Avenue Vero Beach, FL 32960

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 - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38212 Based on interview, policy review and record review, the facility failed to assess a resident's skin under a knee immobilizer to prevent a pressure injury for 1 of 5 sampled residents (Resident #1). The findings included: The facility policy Titled Skin Assessment and revised on 10/01/22 documented in part: 1. A full body or head to toe skin assessment will be conducted by a Registered Nurse upon admission/readmission and weekly thereafter. The assessment may also be performed after a change in condition or after a newly identified pressure injury. The facility policy titled, Pressure Injury Prevention and Management, revised on 10/03/24, documented in part: The facility is committed to the prevention of avoidable pressure injuries. Avoidable means the resident developed a pressure ulcer/injury and that the facility did not do one or more of the following: evaluate the resident clinical condition and risk factors, define and implement interventions that are consistent with resident needs, resident goals and professional standards of practice. Record review revealed on 10/19/24, Resident #1 was transferred from a hospital to the facility. She had diagnosis to include unspecified Fracture of Lower end of Left Femur with encounter for closed fracture with routine healing, Pleural Effusion, Chronic Obstructive Pulmonary Disease, Hypertensive Heart Disease, Muscle Weakness, Difficulty in Walking, Muscle Wasting and Atrophy, Malnutrition, Hypothyroidism, Non-rheumatic Aortic Valve, Periprosthetic Fracture around internal prosthetic left knee joint, Hyperlipidemia, and pain in right hip. Resident #1's admission MDS (Minimum Data Set) assessment dated [DATE] documented the resident had a BIMS (Brief Interview for Mental Status) score of 5, indicating severe cognitive impairment. Further record review revealed Resident #1 arrived at the facility with a left knee immobilizer to secure her knee movements following a fracture of the lower end of her left femur. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106075	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden View Health and Rehabilitation Center	2180 10th Avenue Vero Beach, FL 32960

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/18/24 a pressure injury was found under Resident #1 left knee immobilizer after drainage was discovered from the site. Review of the record for Resident #1 indicates the last weekly skin check before the discovery of the left calf pressure injury was dated 11/04/24 and did not contain any documentation of skin injury on the resident's left calf. The next documented skin assessment was done on 11/18/24. The skin assessment was not documented as completed for 14 days. In reviewing the chart, the DON (Director of Nursing) agreed there was no documentation of a skin assessment for 2 weeks. An interview was conducted on 12/10/24 at 10:21 AM with Staff A, the Director of Rehabilitation. He was asked what the protocol was for removing an immobilizer for skin care and observation. He stated the rehabilitation department never tells nursing services they cannot remove an immobilizer for skin care or skin assessment. He stated it is standard to remove it for care unless there are orders to not remove it. On 12/10/24 at 11:05 AM Staff B, a CNA (Certified Nursing Assistant) was interviewed. She stated she has taken care of Resident #1 many times. She stated she was told by the Physical Therapy (PT) personnel not to remove Resident #1's immobilizer from her leg. She stated she wasn't sure who told her not to remove it. She didn't remove it for care. On 12/10/24 at 11:10 AM Staff C, a CNA was interviewed. She was asked about immobilizers. She stated they always look at the orders to see if the immobilizer is allowed to be removed for showers and peri care. She will follow the orders. On 12/10/24 at 11:12 AM Staff D, a CNA, was interviewed. She was asked about Resident #1's immobilizer; she stated she heard they were not supposed to take it off. She stated she was the one who discovered the drainage on Resident #1 linen, which led to the immobilizer being removed and the discovery of the pressure injury. On 12/10/24 at 11:14 AM, an interview was conducted with Staff E, a RN (Registered Nurse). She was asked about immobilizers and how she performed a skin check when a resident had an immobilizer. She stated she would remove it. She was asked about Resident #1 and her immobilizer. She stated she had removed it when she took care of Resident #1 to check her skin under the immobilizer. Further interview revealed Staff E could not recall the last time she took care of Resident #1. On 12/10/24 at 2:10 PM, Resident #1's Physician was interviewed. He was asked about Resident #1, and he stated the pressure injury under her immobilizer was preventable. He was asked about orders for checking skin integrity. He stated, I wrote protocols for the facility to follow. He stated nursing knows to check skin and circulation under an immobilizer. He stated he now has started writing orders to check skin integrity and circulation for patients with any type of immobilizer.