

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/10/2025
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NAME OF PROVIDER OR SUPPLIER GOLFCREST NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 600 NORTH 17TH AVE HOLLYWOOD, FL 33020
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N 000	<p>INITIAL COMMENTS</p> <p>An unannounced Relicensure survey was conducted on _____ to _____ at Golfcrest Nursing Center. The facility had deficiencies at the time of the survey.</p>	N 000		
N 072 SS=D	<p>59A-4.109(2), FAC; Comprehensive Care Plans</p> <p>59A-4.109 FAC</p> <p>(2) The nursing home licensee develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, mental and _____ needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and social well-being. The care plan must be completed within 7 days after completion of the resident assessment.</p> <p>This Statute or Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to develop and implement a comprehensive person-centered care plan for _____ for 1 of 1 sampled resident reviewed for _____ (Resident #37) and failed to develop and implement a comprehensive person-centered care plan for _____ medication for 1 of 1 sampled resident reviewed for _____ /Behavior (Resident #59).</p> <p>The findings included:</p> <p>1. Record review for Resident #37 revealed the resident was admitted to the facility on _____ with diagnoses that included in part the following: Type 2 _____, and Unspecified Abnormalities of Gait and Mobility.</p>	N 072	<p>F656</p> <p>Resident #37 care plan updated for _____ maintenance and prevention and Resident #59 care plan developed and implemented for _____ medications. 100% audit of residents with _____ medications and _____ for development and implementation of care plans as identified. 100% Inservice of all licensed nursing staff for care plan development and implementation for _____ and _____ medications DON or designee to audit residents on _____ medications and with _____ for care plan development</p>	

AHCA Form 3020-0001 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X8) DATE /25
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N 072	<p>Continued From page 1</p> <p>The Minimum Data Set assessment dated documented in Section C a Brief Interview of Mental Status score of 10, indicating moderate</p> <p>Review of the Physician's Orders for Resident #37 revealed an order dated for cleanse with normal (N/S), dry, apply daily and PRN (as needed) every day shift was discontinued on</p> <p>Review of the Care Plan for Resident #37 dated with a focus on the resident has to related to Immobility. The goal was for the resident's, will show signs of healing and remain free from by/through review date. The interventions included in part the following: Administer treatments as ordered and monitor for effectiveness. Assess/record/monitor healing. Measure length, width and depth where possible. Assess and document status of perimeter, bed and healing progress. Report improvements and declines to the MD. Follow facility policies/protocols for the prevention/treatment of Monitor/document/report PRN any changes in skin status: appearance, color, healing, signs/symptoms of size, stage.</p> <p>In summary the review of the care plan for Resident #37 was not updated to indicate the identified and did not indicate the to the had been resolved.</p> <p>In summary the facility acquired was not updated on the care plan, additionally there were no interventions in place for Resident #37 to prevent the development of a</p>	N 072	<p>and implementation weekly for 30 days and monthly ongoing. DON or designee to report findings of care plan audits to QAPI committee meeting monthly.</p>	
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N 072	<p>Continued From page 2</p> <p>Review of the Care Progress Note by the Care Consultant company dated _____ documented in part the following: location: _____, Length 4 centimeters (cm), Width: 3.2 cm, Depth: 0.2 cm. Status: Recurrent.</p> <p>During an interview conducted on _____ at 12:30 PM with the Minimum Data Set (MDS) Coordinator who stated she is the only MDS coordinator and has worked at the facility for 3 years and in the MDS department for about 3 months. The MDS Coordinator stated that the Dietary department, _____ department and the Social Worker all put in their own care plans, and she does all the nursing care plans. The MDS Coordinator stated she would update care plans as needed based on specific findings. When asked when a resident has a _____ or skin care plan and develop a new _____ would the care plan be implemented or updated, she said yes. When asked what the time frame is to update the care plan when there is a new _____ she said if there is something new it should be updated within couple of days. When asked if there should be interventions in the care plan for prevention of skin issues or _____ especially if the resident has had a _____ in the past, she said yes. The MDS Coordinator acknowledged she did not implement a care plan for the _____ and that the care plan for the _____ should have been resolved a long time ago.</p> <p>2. Record review for Resident #59 revealed the resident was admitted to the facility on _____ with diagnoses that included in part the following: Degenerative _____ of Nervous System, _____, Restless Agitation, and _____. The _____</p>	N 072		
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N 072	<p>Continued From page 3</p> <p>Minimum Data Set assessment dated documented in Section C a Brief Interview of Mental Status could not be done due to the resident is rarely/never understood.</p> <p>Review of the Physician's Orders for Resident #59 revealed in part the following orders: An order dated _____ for _____ Oral Tablet 0.5 MG give 1 tablet by _____ every 6 hours as needed for Agitation related to Restlessness and Agitation for 14 Days and was discontinued on _____.</p> <p>An order dated _____ for _____ Oral Tablet 25 MG give 1 tablet by _____ one time a day for _____ (_____) related to _____ Unspecified and was discontinued on _____.</p> <p>An order dated _____ for _____ Oral Tablet 25 MG give 25 mg by _____ every 12 hours for _____.</p> <p>Review of the Care Plan for Resident #59 revealed there was no care plan for _____ medications including interventions to monitor for behaviors or side effects.</p> <p>During an interview conducted on _____ at 9:30 AM with the Minimum Data Set (MDS) Coordinator who was asked if a resident who has _____ medications ordered would have a care plan, she said they should have a care plan for the _____ medication and include monitoring for behaviors and side effects. When asked about Resident #59, she acknowledged the resident had _____ medications ordered and no care plan in place.</p> <p>Class III</p>	N 072		

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N 110 SS=D	<p>400.141(1)(h) FS; 59A-4.122(1) FAC Physical Environment - Safe, Clean, Homelike</p> <p>400.141(1)(h) FS Maintain the facility premises and equipment and conduct its operations in a safe and sanitary manner.</p> <p>59A-4.122(1) FAC The licensee must provide a safe, clean, comfortable, and homelike environment, which allows the resident to use his or her personal belongings to the extent possible</p> <p>This Statute or Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the residents have a right to a safe, clean, comfortable and homelike environment for 6 of 27 resident rooms observed in the facility.</p> <p>The findings included:</p> <p>1). On _____ at 9:20 AM an observation made in _____ A revealed the following:</p> <p>*The wall behind the bed, was noted to be unsmooth and peeling paint.</p> <p>*The standing fan across from the resident's bed was covered with dust and debris.</p> <p>2). On _____ at 11:30 AM an observation made in _____ revealed an uncovered fluorescent bulb in the entryway, inside of the room.</p> <p>3). On _____ at 11:40 AM an observation</p>	N 110	<p>F584/ N110 Light bulbs replaced in _____ Light covers replaced in _____ and 24, 33 Standing fan cleaned in _____ Walls smoothed and painted in _____ Leaking faucet fixed in _____ , and Call light pull cord removed from grab bar in _____ Resident room environmental rounds completed by Administrator and Maintenance Director Inservice Administrator and Maintenance Director on preventative maintenance rounds and correcting maintenance concerns Administrator or designee to perform resident room environmental rounds weekly for 30 days, and monthly ongoing. Administrator or designee to report findings of environmental rounds to QAPI committee meeting monthly</p>	
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N 110	<p>Continued From page 5</p> <p>made in revealed the following:</p> <ul style="list-style-type: none"> * An uncovered fluorescent bulb in the entryway, inside of the room. * The A/C vents were covered with dust and debris. * The lightbulb in the bathroom was out. * Unpainted plaster on the bathroom wall, next to the soap dispenser *A leaky faucet in the bathroom sink. <p>4). On at 11:30 AM an observation made in revealed the following:</p> <ul style="list-style-type: none"> *An uncovered fluorescent bulb in the entryway, inside the room. *A leaky faucet in the bathroom sink. *A call light pull cord wrapped around the grab bar in the bathroom. <p>5). On at 10:50 AM an observation made in revealed a missing light bulb in the entryway, inside the room.</p> <p>6). On at 11:15 AM an observation made in A revealed an uncovered fluorescent bulb in the entryway, inside the room.</p> <p>A side-by-side tour of the facility was conducted on at 10:20 AM with the Director of Maintenance who stated he has been at the facility for 1.5 weeks and the Administrator who started the week of survey. They acknowledged the above findings. The Administrator stated they will be working on the aforementioned items to get them corrected right away.</p> <p>Class III</p>	N 110		
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N 201 N 201 SS=G	Continued From page 6 400.022(1)(f), FS Right to Adequate and Appropriate Health Care (f) The right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency. This Statute or Rule is not met as evidenced by: A. Based on review of policy and procedure, record review and interview, the facility failed to: 1) promptly notify the ordering physician and promptly administer oral _____ to a resident, in a timely manner, for a resident with a _____ (_____) for 1 of 1 sampled resident (Resident #16); and, 2) failed to accurately document and assess the status and condition for a resident with a skin condition for 1 of 1 sampled resident (Resident #2). The findings included: 1) Record review of the facility policy and procedure titled General Laboratory Information provided by the Director of Nursing (DON), reviewed 2024, documented in the Policy Statement: Communicating Urgent ResultsNotification will be provided to the Principal Investigator, Physician, or his/her authorized representative, as permitted or required by state and federal law, and these authorized personnel will have the responsibility of interpreting the result (s) in the context of the patient's clinical condition. The authorized personnel will be responsible for taking immediate action, if	N 201 N 201	N201 Resident #16 received ordered completed on _____ with no adverse effects. Resident #2 surgical site was dressed and documented on _____ with suture removal Audit of residents with surgical sites for documentation and care plan development and implementation Audit of residents with current orders for _____ for completion of physician notification and prompt start of _____ if indicated. 100% Inservice for all licensed nurses on _____ results with prompt physician notification and prompt start of ordered treatment 100% Inservice for all licensed nurses for documentation of surgical sites and care plan development and implementation for surgical sites DON or designee to audit weekly for prompt notification of _____ results to physician with prompt start of ordered treatment and surgical site documentation	

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N 201	<p>Continued From page 7</p> <p>needed. If the authorized personnel are not qualified to make these decisions, he/she has the responsibility of communicating the information to a qualified person immediatelyAll critical results are called in to the facility, three attempts are made to communicate with resident's nurse, DON or unit manager. If unable to communicate verbal results, Biogalax will send an "Urgent Fax" memo. The "Urgent Fax" form will state the Name, DOB of the patient and 'Attention to Nurse, DON or Unit Manager.' All critical results must be reported to nurse, DON, or unit manager at facility</p> <p>Record review revealed Resident #16 was re-admitted to the facility on _____ with diagnoses which included _____, Type 2 _____ with Complications, _____ and _____, and a History of Recurrent _____. He had a Brief Interview Mental Status (BIM) score of 15, indicative of intact cognition.</p> <p>Review of Resident #16's record documented that the Physician's order had not been entered and uploaded into the facility's computer system by Staff I, a Licensed Practical Nurse, (LPN), until Wednesday _____ at 7:35 PM. Furthermore it was not translated and captured in the system, until later the next day on Thursday _____ and read as such: " _____ Oral Capsule 100 mg (_____ Macro) to give one (1) capsule by _____ two (2) times a day for _____ (_____) for ten (10) days," as ordered by the resident's current primary care physician PCP.</p> <p>There had also been two (2) different previously entered computerized physician's orders which indicated for: 1) _____ and _____ Culture</p>	N 201	<p>with care plan development and implementation. DON or designee to report findings of all audits to QAPI committee meeting monthly.</p> <p>Resident #37 care plan updated for _____ maintenance and prevention 100% audit of residents with _____ for development and implementation of care plans as identified. 100% Inservice of all licensed nursing staff for care plan development and implementation for _____ DON or designee to audit residents with _____ for care plan development and implementation weekly for 30 days and monthly ongoing. DON or designee to report findings of care plan audits to QAPI committee meeting monthly.</p> <p>Resident #51 was sent to hospital on _____ Resident #51 remains in hospital as of _____ Resident # 167 and #169 orders for _____ feeding were clarified and corrected on _____ 100% audit of all _____ feeding residents for _____ orders to meet nutritional needs, one order and RD documentation. Inservice DON and Registered Dietician of documentation and _____ feeding order requirements DON or designee to audit for feeding orders and RD documentation with _____ feeds weekly times 4 weeks and then monthly ongoing.</p>	

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N 201	<p>Continued From page 8</p> <p>dated Monday---"one time only for for one (1) day." And, 2) dated Wednesday---"one time only for for three (3) days."</p> <p>Next, computerized record review of the nursing progress notes entered by Staff I, a Licensed Practical Nurse, (LPN) documented that, on Wednesday at 07:03 AM, "Per outgoing nurse report resident has labs andUnable to collect this shift even after enforcing extra fluid intake. Tried several times, but remained unsuccessful due to patient in adult briefs by the time this writer had gone to him four (4) times. Oncoming nurse will be made aware. Collection cup left at bedside. tubing, specimen envelope and requisition, will be given to relieving nurse." Staff I, also documented on Thursday at 06:15 AM, " + drawn and picked up yesterday results remain pending. Oncoming nurse will be made aware"</p> <p>Further record review of the Laboratory Report for Resident #16 dated revealed that Resident #16's specimen for (E-) had been previously collected on Tuesday, received, resulted and reported on Thursday at 5:43 PM.</p> <p>Additional computerized record review was conducted of the two (2)—a) Physician Progress note dated at 01:00 AM by Resident #16's PCP documented"Nursing has concerns regarding change in mental status, but patient appears to be at baseline mental status, CMP, ammonia, A1C ordered for" and b) Physician Progress note dated at 01:00 AM by Resident #16's PCP</p>	N 201	DON or designee to report findings of audits to QAPI committee meeting monthly.	
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N 201	<p>Continued From page 9</p> <p>documented "including change in mental status", "Change in Mental Status () Workup initiated: , CMP, ammonia, UA/UCx. Continue frequent mental status monitoring." As well as, progress notes documented by the Resident's Physician Assistant's (P.A.'s), progress note visit entered on Tuesday , revealed that the abnormal culture results had been first identified and discovered by the P.A.", who in turn documented the following entry in the facility record, " with new + E- . Will start 100 mg x ten (10) days"</p> <p>There was no documentation noted in the nurses' progress notes dated from Wednesday at 07:03 AM through at 06:59 AM, to indicate if, when or what time the ordering physician had been notified of these abnormal culture results, by the facility.</p> <p>However, further review of Resident #16's , Medication Administration Record (MAR), documented for the 100 mg was not started until Thursday at 09:00 AM, which is approximately one week after the lab results were reported to the facility.</p> <p>On at 06:59 AM, Staff I, also documented, " Diagnosis: with to be started this morning as ordered x 10 days (until Wednesday). Medication received this morning from pharmacy"</p> <p>A brief telephone interview was conducted on at 2:06 PM with the a supervisor at the Diagnostic laboratory to clarify the date and time the facility received the results was at 5:43 PM. He state he would speak with someone and get to this surveyor, however, there was</p>	N 201		
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N 201	<p>Continued From page 10</p> <p>no response received during the survey.</p> <p>A telephone interview was attempted on at 2:22 PM with Resident #16's Physician's Assistant/PCP, in order to ascertain whether or not the physician's office had been notified of Resident #16's abnormal and culture result of (E-), by the facility. This Surveyor left a voice message. However, there was no response received during the survey.</p> <p>A telephone interview was conducted on at 9:33 AM with Staff I, in order to ascertain whether or not Resident #16's "abnormal" culture results had been promptly reported to the ordering physician. Staff I also acknowledged that the "abnormal" culture lab work had previously been collected on , and reported to the facility on at 5:43 PM, per the lab report. When asked, did you document in the resident's record that you promptly notified the resident's ordering physician of the abnormal culture result, she responded, by saying that, "another nurse may have." And Staff I was also asked if she knew why there had been a seven (7) day delay between receiving Resident #16's "abnormal" culture lab work and in Resident #16 finally receiving his oral . Staff I responded by saying that, she was not working that whole time and she did not know. However, Staff I, acknowledged that the next nurse should have followed up to find out if the lab results had been obtained so that the resident could have received proper treatment, as indicated.</p> <p>During an interview conducted on at 3:22 PM with the DON, she was also asked to describe the process that occurs when an</p>	N 201		
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N 201	<p>Continued From page 11</p> <p>abnormal lab result report comes in, and who would be responsible for notifying the Physician of this and where would it be documented. The DON responded by saying that, "the laboratory would call the facility directly, whenever there was an "abnormal or critical" lab result. And, she said that the lab would ask to speak to a nurse, take his or her name, and would then fax over the "abnormal" lab result to the main fax machine located on the West wing across from the nurses' station, at the facility. Then, the DON said that the "assigned nurse" would be responsible for reaching out and contacting the ordering physician ASAP, with the "abnormal" lab results. Next, the DON indicated that the responsible nurse would "initial" the result, note that the Physician was notified, and would place the "abnormal" lab result in the box, located at the nurses' station, to be uploaded into the system the next morning, by their medical records department. The DON ended by acknowledging that there was no book or tracking log, at this time, in place to record and store the resident's "abnormal" lab results, in the facility.</p> <p>Staff member J, a Registered Nurse (RN), who had been working on Thursday at 5:43 PM, when the lab result was reported in from the lab, was no longer working with the facility and unavailable for an interview.</p> <p>There was no care plan on file specifically for " , " care, for this resident.</p> <p>In fact, the physician notification and subsequent order for Resident #16's oral had not been performed nor obtained prior, by the facility. The physician's order for treatment was not initiated, with an intervention until five (5) days later, after it was first discovered by the</p>	N 201		
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N 201	<p>Continued From page 12</p> <p>Physician's Assistant.</p> <p>In Summary, the oral _____ had not been started and administered to Resident #16 until seven (7) days after the "abnormal" lab results had been reported to the facility by the laboratory.</p> <p>The DON further recognized and acknowledged on _____ at 3:30 PM that facility nursing staff, should have followed through with promptly notifying the ordering physician and she also indicated that there should not have been a delay of seven (7) days between the facility having received an "abnormal" _____ culture result and for Resident #16 finally having received his ordered oral _____ for treatment.</p> <p>2) Record review of the facility policy and procedure titled _____, Non-Sterile provided by the Director of Nursing (DON), reviewed _____, documented in the Policy Statement: This procedure may involve potential/direct exposure to _____, air _____, contaminants, and hazardous chemicals. Purpose: The purposes of this procedure is to provide guidelines for non-sterile _____ changes to protect _____ from injury and to prevent the introduction of _____. Steps in the Procedure: ...15. Observe the _____ and surrounding skin ...Reporting and Documentation: The following information ...be documented in the resident's electronic record medical record: 1. The date and initials of the person that performed the procedure. 2. Type of _____ used and care give.....</p> <p>Record review revealed Resident #2 was re-admitted to the facility on _____ with diagnoses which included _____ of Shaft of</p>	N 201		

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N 201	<p>Continued From page 13</p> <p>Left , Subsequent Encounter for Closed with Routine Healing, . Unspecified and Generalized . She had a Brief Interview Mental Status (BIM) score of 5, indicating severe .</p> <p>During an observational tour conducted on at 11:03 AM, Resident #2 was observed, her left pant partially pulled up, with a "partially attached" located on her left upper front area with two (2) "exposed and uncovered" noted underneath. And, upon closer observation of Resident #2's left just above her left , she was observed to have four (4) additional "exposed and uncovered" noted. Photographic Evidence Obtained. Resident #2 was asked, "in general" if she had any , at this time and she replied, "yes, sometimes she has an intermittent "pressure" type , from the top of her left to her upper left , level , for which she gets medication for. It was noted that the edges of both with were well approximated, with no redness or drainage noted, at this time.</p> <p>Record review of the current physician's orders dated documented, "Left lower extremity: Clean surgical site with normal (N/S), , dry, apply Xeroform, cover with protective . . . daily."</p> <p>Record review of Resident #2's re-admission note dated documented, " . . . Left behind left from the . . . Skin is warm and dry to touch.</p> <p>However, further record review of all subsequent nursing progress dated from . . . until , makes no mention of the existence,</p>	N 201		
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N 201	<p>Continued From page 14</p> <p>presence, current status nor current condition of Resident #2's "exposed and open to air" or surrounding skin, on her left lower , nor on the upper portion above her left .</p> <p>An additional record review of a progress note dated . by Staff K, an RN, in which it was documented, "Resident left . changed: cleanse with N/S, . dry, apply Xeroform, cover with protective . dry and clean no sign of . noted, no . redness, drainage noted, no complaints of . Treatment in place will continue to monitor." Again, there was no mention of the existence, presence, current status nor current condition of Resident #2's or surrounding skin on her left lower , nor on the upper portion above her left .</p> <p>During a subsequent observation conducted on at 11:04 AM, Resident #2 was now observed with three (3) , all initialed and dated . , with one (1) located on the area above her left , a second one located to the resident's left upper and a third one located on the resident's lower outer front area covering the previously seen " . " of the two (2) upper skin . areas. Photographic Evidence Obtained.</p> <p>During a brief interview conducted on at 11:04 AM with Resident #2's assigned nurse Staff L, RN, she stated that all three (3) had been changed earlier that morning by Staff E, an RN, and by the Assistant Director of Nursing (ADON).</p> <p>An interview was conducted on at 2:45 PM with the ADON, in which she acknowledged that she did assist Staff E, during the .</p>	N 201		
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N 201	<p>Continued From page 15</p> <p>change to Resident #2's left lower _____ earlier that morning at 7 AM, and she acknowledged that Resident #2 did have _____ in place in her left lower _____ at various locations. The ADON also acknowledged, as recorded in the resident's Treatment Administration Record (TAR) dated _____ and _____, that Staff K had also initialed that she had done the _____ changes to the left lower extremity for Resident #2. However, she also stated and noted that neither Staff K, nor Staff E, had documented anything regarding the existence, presence, current status nor current condition of Resident #2's _____ or surrounding skin on her left lower _____, nor on the upper portion above her left _____, in Resident #2's record for the date of _____.</p> <p>There was no care plan "specifically" _____ Resident #2's surgical _____ and _____. Moreover, there was no record of the nursing progress note for the _____ change performed on _____ at 7 AM, for this resident's left lower _____.</p> <p>Record review was also conducted of the TAR for the dates of Monday _____, Tuesday _____, by Staff K, and for the date of Wednesday _____, by Staff E, RN, Staff nurse, who performed the left lower _____ change, all indicated with "initials" that the _____ had been done and the physician's order was: "Left lower extremity: Clean surgical site with N/S, _____ dry, apply Xeroform, cover with protective _____ daily one time a day - Start Date Monday _____ at 0800 AM."</p> <p>Nonetheless, there had still been no mention of the existence, presence, current status, nor current condition detailing Resident #2's _____ or surrounding skin on her left lower _____ and on _____.</p>	N 201		
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N 201	<p>Continued From page 16</p> <p>the upper portion above her left , anywhere in the resident's record for either of these three (3) above dates.</p> <p>The DON recognized and acknowledged on at: 3:14 PM, that the resident's complete skin status, including her , should be assessed and should have been documented in detail in the resident's record.</p> <p>B. Based on observations, interviews and record review the facility failed to ensure that a resident receives care, consistent with professional standards of practice, to prevent , and does not develop , for 1 of 1 sampled resident reviewed for , (Resident #37).</p> <p>The findings included:</p> <p>Record review for Resident #37 revealed the resident was admitted to the facility on with diagnoses that included in part the following: Type 2 , and Unspecified Abnormalities of Gait and Mobility. The Minimum Data Set assessment dated documented in Section C a Brief Interview of Mental Status score of 10, indicating moderate</p> <p>Review of the Physician's Orders for Resident #37 revealed in part the following orders:</p> <p>*An order dated Weekly skin assessment every Tuesday 7:00 AM to 7:00 PM Shift.</p> <p>*An order dated for , cleanse with normal (N/S).</p>	N 201		

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N 201	<p>Continued From page 17</p> <p>dry, apply daily and PRN (as needed) every day shift was discontinued on</p> <p>*An order dated : Cleanse with N/S, dry, apply daily and PRN (as needed) every day shift for</p> <p>*An order dated for air mattress.</p> <p>*An order dated to encourage resident to turn and reposition frequently.</p> <p>Review of the TAR (Treatment Administration Record) for the month of had no documentation of care to the was provided on</p> <p>Review of the Progress Notes for Resident #37 from to revealed no documentation of turning or repositioning the resident nor was there documentation of the resident refusing to be turned and repositioned.</p> <p>Review of the Care Plan for Resident #37 revealed no care plan for the or prevention of</p> <p>Review of the Care Progress Note by the Care Consultant company dated documented in part the following: location: , Length 4 centimeters (cm), Width: 3.2 cm, Depth: 0.2 cm. Status: Recurrent.</p> <p>An interview was conducted on at 11:05 AM with the Assistant Director of Nursing (ADON) who stated she has worked at the facility or 1 year. When asked how do you identify if a resident is high risk for development of , the ADON stated by doing a</p>	N 201		

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N 201	<p>Continued From page 18</p> <p>screening and assessment and history of resident. They are done on admission, depending on the score of the screening or assessments it will populate to reassess the resident. If the resident is high risk when it would populate for a reassessment again but does not know the exact time frame for the reassessment to be completed next. When asked about Resident #37, the ADON stated the resident had a screening done on that documented a score of 7 indicating less than 8 not high risk for developing a . On the resident had a</p> <p>Predicting Risk documenting a score of 17 indicating at risk for developing a</p> <p>The ADON verified the resident had an order dated for skin checks every Tuesday 7:00 AM to 7:00 PM shift. The licensed nurse weekly skin observation were completed on , and . The ADON acknowledged the weekly skin checks were not performed weekly as ordered.</p> <p>The ADON then stated on documented in an Exception report was however she believes this was documented as in error and should have been a . The documentation on of as . When asked if the care to the was documented as performed on as ordered, the ADON acknowledged there was no documentation of the care being performed.</p> <p>An interview was conducted on at 10:30 AM with Staff A, Certified Nursing Assistant (CNA), who stated she has worked at the facility for 7 years. When asked does she turn and</p>	N 201		
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N 201	<p>Continued From page 19</p> <p>reposition residents and if so how often, she said they turn and reposition residents every 2 hours. When asked where she documents the turning and repositioning, she said they do not have a place for her to document this in the electronic medical record.</p> <p>An interview was conducted on _____ at 10:45 AM with Staff B, Registered Nurse (RN), who stated she has worked at the facility since 2020. When asked what interventions the facility uses to prevent _____ or _____ she said they do weekly skin check and turn and reposition the resident's every 2 hours. When asked where this is documented, she said the weekly skin assessments are documented in the Weekly Skin Check Assessment. When asked about the documentation for turning and repositioning, she said only if there is an order they are documented on the TAR (Treatment Administration Record) or they can document on a progress note.</p> <p>During an interview conducted on _____ at 1:30 PM with the Director of Nursing (DON) who was asked about Resident #37 and she stated some nurses had documented a _____ but not any measurements or staging, she said this may have been documented incorrectly, because all of the orders for treatment were for _____ at the time when this documentation was in effect in late _____ to early _____. The 3008 form from the transferring hospital dated _____ documented skin condition of _____ and _____ as having road _____. The DON acknowledged there was no evidence in the resident's medical record that she had a _____ on her _____ while at the facility. The DON provided a statement on letterhead signed _____</p>	N 201		
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N 201	<p>Continued From page 20</p> <p>by her and dated "Resident #37 does not have any history of , on her ."</p> <p>During a telephone interview conducted on at 1:45 PM with the Advanced Registered Nurse Practitioner (ARNP) from the care company who was asked about the documentation of the care for Resident #37 dated , she said she put recurrent because that is what the DON had told her that the resident had a in the past. She stated this was the first time she had seen the resident, and she did not review the chart, she just documented based on what the DON had told her.</p> <p>C. Based on observations, interviews, and record reviews, the facility failed to provide nutritional assessments and interventions in a timely manner which resulted in significant loss for 1 of 1 sampled resident (Resident #51); The facility also failed to follow Physician's orders for 2 of 5 sampled residents (Resident #167 and Resident #169).</p> <p>The findings included:</p> <p>A review of the facility's policy titled "Weighing and "at-risk" Protocol" and revised in showed the following:</p> <p>Nursing to complete all with on the following parameters: 0- variances of - loss or gain.</p> <p>Identification: When all (weekly and monthly) are completed, the Dietary Department will review for significant loss and "at risk" loss and determine variances with as noted above. The Dietary Department will notify nursing staff of significant</p>	N 201		

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N 201	<p>Continued From page 21</p> <p>and "at risk" residents the next day during the morning meeting. Investigation: The Dietary Department and nursing staff begin investigating loss: Is the Resident assisted with eating? Is Staff assisting with eating appropriately? Giving enough time? Does the Resident like food? Have food preferences? Family involved in bringing food? Intervention: Notify Dietitian of newly identified significant loss. Review intakes at a minimum weekly. Documentation: Dietary will document within 72 hours of investigation. Dietary to document monthly until resolved. Review weekly with nursing and dietary until loss resolved. Keep minutes of the meetings. Resident reviewed, and interventions initiated on all residents with significant loss and "at risk."</p> <p>A review of the American Society for Parental and Nutrition titled "Standards for Specialized Nutrition Support for Adult Residents of Long-Term Care Facilities" dated showed the following: Monitoring and Re-evaluating the Nutrition Care Plan, Parameters and Frequency: The frequency of monitoring should depend on the severity of illness, degree of stress, and level of stress. Daily or more frequent monitoring should be required in residents who are critically ill, have unstable debilitating or complications, are at risk for refeeding between feeding and oral diet, or have experienced complications.</p> <p>https://aspenjournals.onlinelibrary.wiley.com/doi/10.1177/011542650602100196.</p> <p>A record review showed that Resident #51 was admitted on and readmitted to the facility on with diagnoses of</p>	N 201		
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N 201	<p>Continued From page 23</p> <p>5.9% loss in a month.</p> <p>From to (36 days), severe %.</p> <p>From to (67 days), showed a severe %</p> <p>From to (3 months), showed a severe %</p> <p>Resident #51 had an overall significant trending % from to (past 8 months).</p> <p>The monthly taken on was due to this Surveyor's intervention in attempting to obtain a monthly before Resident #51 left for the hospital.</p> <p>A chronological review of the orders indicated the following:</p> <p>In : Feed Order 1.5 at 60 ml per hour for 20 hours at 2:00 PM and off at 10:00 AM. This started on and was discontinued on</p> <p>In : an order was placed for feed two times a day 1.5 at 60 ml per hour for 12 hours on at 7:00 PM and off at 7:00 AM. This started on and discontinued on</p> <p>An order was placed for feed every night shift .5 at 60 ml/hr. for 12 hours on at 6:00 PM and off at 6:00 AM. This started on and discontinued on</p>	N 201		

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N 201	<p>Continued From page 24</p> <p>From _____ to _____, Resident #51 was only on _____, which was not meeting her needs and was decreased from 20 hours to 12 hours a day on _____.</p> <p>In _____, an order was placed for an _____ feed every night shift, _____ 1.5 _____ 60 ml per hour for 12 hours at 6:00 PM and off at 6:00 AM. This started on _____ and was discontinued on _____.</p> <p>An order was placed for a no-add-salt, low-concentrated sweet diet, mechanical soft texture, regular/thin consistency, and fortified foods for all meals, which started on _____ and was discontinued on _____.</p> <p>In _____, an order was placed for a regular, no-added-salt diet with a puree texture and nectar-thick consistency and no fortified food from _____ to _____.</p> <p>In _____, several orders were placed: from _____ to _____, a regular no-added-salt diet with a mechanical soft texture; from _____ to _____, a no-added-salt diet and low-concentrated sweet diet with a mechanical soft texture; from _____ to _____, a regular no-added-salt diet with a mechanical soft texture; and from _____ to _____, an order for Boost twice a day.</p> <p>In _____: an order was placed for feed two times a day Jevity 1.5 at 50 ml/hr. for 12 hours, to be run until 600 ml infused, on at 6:00 PM and off at 6:00 AM which started on _____.</p> <p>An order was placed for a regular diet mechanical soft texture on _____.</p>	N 201		

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N 201	<p>Continued From page 25</p> <p>An order was placed to add fortified foods with all meals on</p> <p>A review of the orders indicated that Resident #51 spent 54 days (from _____ to _____) only being fed by _____ with no order of feeding. Further review showed a second decrease in the tube from 60 ml/hr. to 50 ml/hr. from _____</p> <p>A review of the Dietary progress note dated _____ (the day after Resident #51 got readmitted to the facility from the hospital) revealed the following: The Registered Dietitian stated that Resident #51 estimated needs were 1825-2190 kilocalories, 73-88 grams of protein and 1825-2190 milliliters(ml) of fluids. Resident #51 was put on pleasure feeding of pureed/thin and tolerated the _____ well with no issues. The Dietary progress note further revealed an order clarification to _____ 1.5 (_____) formulary) at 60 ml x 20 hours (hrs.), flush with 50 ml for 20 hours, providing 1800 kilocalories (kcal), 99 grams (G) of Proteins and 1911 milliliters of total fluids, which will be meeting the lower end of the resident caloric needs and meeting over 100% of proteins.</p> <p>A review of the Dietary progress note dated _____ (135 days after the previous Dietary progress note) revealed the following: The Registered Dietitian stated that Resident #51 _____ and has a normal _____ (_____) of 23.4 for _____. The _____ progress note further indicated that Resident #51 _____ loss was likely due to the transition from _____ to per oral with variable intake. A recommendation of: Boost 1 can (240 ml) by _____ 2 times a day and fortified cereal at _____</p>	N 201		

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N 201	<p>Continued From page 26</p> <p>Breakfast with a diet of no added salt (NAS), mechanical soft, thin liquids were put in place.</p> <p>A review of the Dietary progress note dated (the day after the 5.1% loss was identified) revealed the following: The Registered Dietitian stated that Resident #51 had significant loss respectively for 1 month: 5.1%, 3 months: 11.8% and 6 months: 21.6% with a normal for the and a . Further review showed a recommendation to discontinue: No added salt restriction, clarify diet to a regular, mechanical soft texture, thin liquids, and fortified food with meals. A re-estimation of the needs based on current indicated Kcal: 1770-2065, Protein: 59-77g, Fluids: 1770-2065 ml. A recommendation to re-start nocturnal feeds was placed with Jevity 1.5 (formulary) at 50 ml per hour for 12 hours, run until 600 ml infused via tube () (on 6 PM, off 6 AM), water flush at 40 ml/hr and for 12 hours, run until 480 ml infused via (on 6:00 PM, off 6:00 AM). It will provide 900 kcal, 38g protein, 936 ml free water, and 1080 ml total fluids. The new recommendation of will be missing 870 kcal, 21g of protein, and 690 ml of fluids to meet the lower end of Resident #51's nutritional need, which would be provided from the diet intake by (PO).</p> <p>A review of the Dietary progress note dated revealed the following: The Registered Dietitian (RD) stated that Resident #51 and had a of 22.5 on , which indicated loss resolved due to a 1- gain since . A recommendation was made to continue a no added salt diet with a mechanical soft texture and</p>	N 201		

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N 201	<p>Continued From page 27</p> <p>thin liquid PO. The RD further stated that Resident #51's intake varies from 25% to 75%. A recommendation is to continue supplemental feeds of Jevity 1.5 at 50 ml per hour for 12 hours starting at 6:00 PM daily until 600 ml has been infused (900 kcal and 42.5 grams of protein and 450 ml of free water). A review of the progress note further revealed a _____ of Resident #51 nutrient and hydration needs with PO diet and _____ regimen: Energy need: 1500-1800 kcal, Protein needs: 60-72 grams, and Fluid needs: 1500-1800 ml. This indicates that the _____ feeding of 900 kcal, 42.5g of protein, and 450 ml of free water is not meeting the Resident's nutritional and hydration needs. The RD also stated that the regimen is well tolerated, with no signs and symptoms of distention/cramping, fluid overload, or _____.</p> <p>A review of the doctors' progress note dated _____ indicated under the treatment section and sub-section of attention to _____ tube a recommendation of _____ 1.5 _____ at 60 ml per hour for 20 hours at 2 PM and off at 10 AM. A review of the orders showed that this recommendation was never placed in the orders.</p> <p>A review of the care plan initially dated _____ and revised on _____ stated that Resident #51 is at risk for nutritional and hydration problems. Risk related to nocturnal _____ as a supplement route of nutrition and hydration associated with Cerebro Accident. Medical diagnoses included _____ failure, _____ Essential _____, Hypnatremia, _____, _____ (_____), and _____ (_____). Mechanical soft diet provided PO at all meals.</p>	N 201		
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N 201	<p>Continued From page 28</p> <p>A review of the past 30 days (from _____ to _____) of the amount eaten showed various percentages of food intake for Resident #51: 16 meals between 0 and 25%, 13 meals between 26 and 50%, 51 meals between 51 and 75% and 8 meals between 76 and 100%.</p> <p>In an observation conducted on _____ at 5:46 PM, Human Resources staff, Staff R, was seen setting up the tray and leaving the room right after. At 6:10 PM, the tray was still untouched; Resident #51 only ate the dinner roll and the cake. At 6:13 PM, Certified Nurse Assistant, Staff S, wrote 30% of the intake on Resident #51's meal ticket and took the tray out of the room.</p> <p>In an observation conducted on _____ at 6:25 PM, Registered Nurse (RN) Staff T was seen writing Resident #51's information, including the _____ start time (6:25 PM) on the _____ bottle. After setting up the feeding, the Staff realized the _____ was missing a "part" and called Registered Nurse Staff U for help. Staff T stated that she always sets up the _____ for Resident #51 at night because during the day the Resident eats by _____.</p> <p>In another observation conducted on _____ at 6:40 PM, this Surveyor observed that the feeding started at 6:42 PM, but the monitor stopped and displayed an error message due to "clogs." After multiple attempts, _____ finally started at 6:50 PM.</p> <p>In an observation conducted on _____ at 5:40 AM, Resident #51 was awake in bed with no _____ bottle running or noted in the room. Staff V, RN, stated Resident #51 _____ all over the bed and she stopped the _____ at 5:30</p>	N 201		
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N 201	<p>Continued From page 29</p> <p>AM. The bottle was about half full when she stopped it. Staff V stated that Resident #51 usually tolerates her _____ well with no issues.</p> <p>An order was placed on _____ to send Resident #51 to the Emergency Room for coffee ground _____ identified on _____.</p> <p>In an interview conducted on _____ at 8:00 AM, the Director of Nursing (DON) stated that specific staff members take the _____ on all residents, and the list is then given to Staff D, Medical Records, to put in the electronic system. Staff D calls the Registered Dietitian to discuss any _____ losses before recording them in the electronic system. The DON said Resident #51's _____ was taken on _____ but was not able to provide one and then said, "Maybe it was written on a piece of paper".</p> <p>In an interview conducted on _____ at 8:12 AM with Staff D, she stated she has two staff members who take the _____ on all residents, and the list is then given to her to record in the electronic system. The monthly _____ are taken on all residents from the 1st to the 5th of the month. If a resident has lost _____, the Registered Dietitian will ask for a reweigh to ensure the accuracy of the _____. For any weekly _____, the Registered Dietitian will provide her with a list of residents. When asked about the facility's policy for _____, Staff D stated residents' _____ are taken on admission, once a week for 4 weeks, and monthly thereafter. For the monthly _____, the Registered Dietitian (RD) reviews all residents in the electronic system on a regular basis and will ask for a reweigh if any discrepancies. The RD comes to the facility once a week and has remote access</p>	N 201		
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N 201	<p>Continued From page 30</p> <p>as well to be able to assess the residents when not in the facility. When asked if the monthly _____ was taken on Resident #51, Staff D said, "It might have slipped us a little bit" when we did all the monthly _____ from the 1st to the 5th of this month.</p> <p>According to Staff D, the RD can see any significant/severe _____ losses when she reviews the _____ of all residents. If she sees any _____ loss, she will notify the RD as soon as possible.</p> <p>In an interview conducted on _____ at 11:00 AM, Resident #51's daughter (her caregiver) stated that she realized that her mother had lost a lot of _____ and that she had been wanting to talk to someone. She said: "I've been _____ lately because that's not my mom". Resident #51's daughter said her mother used to weigh between 200 and _____ and that she is very concerned about the _____ loss and how her mom looks now. Especially since she always attends all the care plan meetings and _____ loss was never addressed or her preferences. She further explained that her mother doesn't like the food served in the facility, and that may be the reason why she only eats the sweets that are served. Resident #51's daughter stated that sometimes the Staff tells her that her mother eats 60% but doesn't believe it because her mother barely eats 30% when she is present, which is about 3 times a week.</p> <p>In an interview conducted on _____ /1015 at 12:30 PM, the Registered Dietitian (RD) stated that she started working for this facility on _____ and works between 15 to 20 hours a week and comes only on Fridays. RD explained that she sees the residents on Fridays when she comes and logs in</p>	N 201			

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N 201	<p>Continued From page 31</p> <p>every day to see new admissions. If a new resident is admitted with something "crucial" like _____, she calls the Director of Nursing and tries to do the assessment within 24 hours and after monthly. RD further explained that if a resident is on pleasure feeding, then the _____ must meet all the resident's needs. A resident on _____ is considered at high risk, and to take a resident off the _____ one of the criteria is that the resident is consistently eating 75% or more. As for the _____ RD explained that she runs an "exception report" between last month and this month, which tells her what happened so she can make the necessary adjustments. RD did not adjust the _____ for Resident #51 because Resident had a 1- _____ gain and was waiting for the monthly _____ to consider changes. When asked by this Surveyor if she visited Resident #51 or spoke to her daughter regarding food likes and preferences, she said no.</p> <p>The current facility Registered Dietitian did not reweigh Resident #51 or adjust the estimated needs of the Resident due to the 1- _____ gain and did not consider the trending significant _____ loss for the last 6 months.</p> <p>In an interview conducted on _____ at 2:28 PM, the Director of Nursing (DON) stated that she had four different dietitians in 6 months. There was no dietitian coverage from _____ to _____. The DON further explained that the expectation for a resident on _____ is to be seen weekly by the RD, and if residents are stable, then the visits should be monthly. She also expected the RD to recognize the _____ loss on Resident #51 and acknowledged that no RD notes were placed for Resident #51 from _____ to _____ (4 months).</p>	N 201		
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N 201	<p>Continued From page 32</p> <p>In an interview conducted on _____ at 2:45 PM with a Registered Nurse, Staff E stated that she is familiar with Resident #51. She further stated that Resident #51 tolerates _____ well and has been eating between 50% and 60% on average.</p> <p>In an interview conducted on _____ at 3:00 PM with Medical Records, Staff D stated that she has been working at the facility for 6 years and is very familiar with Resident #51. Staff D explained that Resident #51 would drink a lot but only ate 25% more or less.</p> <p>In an interview conducted on _____ at 2:25 PM with a Certified Nurse Assistant (CNA), Staff P stated that she is familiar with Resident #51 and that her food intake depends on the type of food. For example, for Breakfast, she will eat 50% some days, but for lunch and dinner, she wouldn't eat more than 25%. Staff further stated that Resident #51 is not a big eater, and that Breakfast is the best one for her.</p> <p>In an interview conducted on _____ at 2:30 PM with the Registered Nurse, Staff Q stated that she is familiar with Resident #51. Staff Q explained that Resident #51 likes to drink (coffee, milk, and orange juice) more than eat. Her food texture changed on multiple occasions from pureed (because she did not want it) to regular texture. Once it was changed to a regular texture, Resident #51 started choking, so it had to be changed to mechanical chopped. Staff Q further stated that as the RN on the floor, the CNAs come to her and inform her of Resident #51's intakes. Breakfast is her best food, and she eats 50% of it.</p>	N 201		

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N 201	<p>Continued From page 33</p> <p>In an interview conducted on _____ at 2:10 PM, Resident #51's daughter (caregiver) stated that she is not happy with the _____ loss; her dad cried when he saw his wife at the hospital because she had lost so much _____; "That should have never happened in the first place, they should have been feeding my mom properly." The Resident's daughter further reported that the doctor at the hospital explained that her mother would never be able to eat by _____ again.</p> <p>Baker, Iris</p> <p>2. Resident #167 was admitted to the facility on _____ with diagnoses of _____ Failure, and _____. A review of the Physician's order noted two overlapping orders for _____. If vital AF 1.2 (_____ formulary type) is not available, may substitute with Peptamen 1.5 (_____ formulary type) at 240 milliliters (ml) every 4 hours dated _____. Another order was noted for 20 hours at 10:00 AM and off at 2:00 PM. Feeding: Vital Advanced Formula, 1000ml, 55ml an hour, which was dated _____.</p> <p>A review of the Medication Administration Record showed that both above _____ orders were checked as administered in _____.</p> <p>In an observation conducted on _____ at 10:35 AM, Resident #167 was noted in bed with the _____ Peptamen 1.5 at 50ml an hour, which was dated _____, but no start time. The _____ was noted at the 750ml mark out of the 1000ml capacity bag.</p> <p>In an observation conducted on _____ at 3:30 PM, Resident #167 was noted in bed with the _____.</p>	N 201		
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N 201	<p>Continued From page 34</p> <p>Peptamen 1.5 at 50ml an hour, which was dated , but no start time. The was noted at the 700ml mark out of the 1000ml capacity bag. This showed that only 50ml was administered in the last 1 hour and a half.</p> <p>In an observation conducted on at 5:20 PM, Resident #167 was noted in bed with the continuous Peptamen 1.5 at 50ml an hour, dated , and no start time. The was noted at the 600ml mark out of the 1000ml capacity bag, which showed that 100ml was infused in the last 2 hours.</p> <p>In an observation conducted on at 5:48 AM, Resident #167 was noted in bed with the on hold. The bag started at 5:00 AM on and was at the 900ml mark out of a 1000ml capacity bottle.</p> <p>In an interview conducted on at 1:00 PM with Staff F, the Registered Nurse stated she only realized this morning when she started her shift that Resident #167 had two orders. She asked the Nurse supervisor to check the orders and update them accordingly. Staff F acknowledged that both orders were checked as given in the MAR under each specific order.</p> <p>A review of the log revealed Resident #167's admission , dated . A new was obtained on as per this Surveyor's request, which showed Resident #167 was at , indicating a 2- loss.</p> <p>In an interview conducted on at 1:30 PM with Resident #167 son stated his father used to</p>	N 201		
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N 201	<p>Continued From page 35</p> <p>be around about a year ago and has been in and out of the hospitals for some time.</p> <p>The nutrition assessment dated showed the following: Resident #167's Ideal Body . He does not eat anything by , and his only route of nutrition and hydration is feeding. This assessment addressed the order of Vital AF 1.2 every 4 hours but not the continuous order of with Vital Advanced Formula, 1000ml, 55ml an hour. Resident #167 was noted at and that the current order was meeting needs.</p> <p>A new order for 20 hours of feeding-Peptamen (formulary)1000ml,60ml, and hour, dated was noted.</p> <p>A review of the Care Plan showed Resident #167 has nutritional and hydration problems related to nothing by status and medical history. It further revealed that feedings and flushes should be provided as ordered.</p> <p>3. Resident #169 was readmitted to the facility on with diagnoses of , and . The Minimum Data Set (MDS) dated showed Resident #169 had a Brief Interview of Mental Status () score that is severely . A review of the Physician 's orders revealed an order for every shift of Peptamen 1.5 at 70ml an hour times 20 hours. The feed starts at 2:00 PM daily until a total volume of 1400ml has been infused. It may be substituted with 1.5 (formulary) if Peptamen 1.5 is</p>	N 201		

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N 201	<p>Continued From page 36</p> <p>unavailable, as dated _____.</p> <p>A review of the _____ log showed the following _____:</p> <p>_____</p> <p>In an observation conducted on _____ at 12:12 PM, Resident #169 was noted in bed with the _____ Peptamen 1.5 running at 60ml an hour. The _____ was noted at the 800ml mark out of a 1000ml capacity bag, which was dated _____ but had no start time.</p> <p>In an observation conducted on _____ at 3:33 PM, Resident #169 was noted in bed with the _____ Peptamen 1.5 running at 60ml an hour, which was dated _____ but had no start time. The _____ was noted at the 700 mark out of the 1000ml capacity bag. This showed that 100ml was administered in the last 3 hours, from 800ml to 700ml.</p> <p>In an observation conducted on _____ at 5:20 PM, Resident #169 was noted in bed with the _____ Peptamen 1.5 at 60ml an hour, which was dated _____, but no start time. The _____ bag was noted at the 600ml mark out of a 1000ml capacity bottle. Only 200ml of formulary was administered in the last 5 hours, and not the necessary 350ml of formulary.</p> <p>In an observation conducted on _____ at 6:20 AM, Resident #169 was noted in bed with the _____</p>	N 201		
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N 201	<p>Continued From page 37</p> <p>Peptamen 1.5 running at 60ml an hour. The bag had a start date of _____ with a start time of 5:00 AM. It was also noted at the 900ml mark out of a 1000ml capacity bag. In this observation, Staff G, a Registered Nurse, stated Resident #169 tolerated his _____ well. She further said that she started the _____ a little less and increased it to where it needed to be when Resident #169 was more elevated with his _____ on the bed.</p> <p>The Nutrition assessment dated _____ revealed the following: Resident #169 is at risk for _____ with a _____ % over the past 30 days, likely due to _____ dislodgement and replacement. The current _____ order of Peptamen 1.5 at 60ml an hour for 20 hours is meeting estimated needs.</p> <p>A follow-up nutritional note dated _____ showed Resident #169 had a _____ () of _____ status. The _____ regimen is adequate in nutrients to meet his current needs. The Clinical Dietitian _____ the energy and protein needs and recommended increasing the _____ regimen to 70ml an hour from 60ml an hour. This was not followed in the above observations.</p> <p>Class II</p>	N 201		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105009	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/10/2025
NAME OF PROVIDER OR SUPPLIER GOLFCREST NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 600 NORTH 17TH AVE HOLLYWOOD, FL 33020	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Recertification survey was conducted on _____ to _____ at Golfcrest Nursing Center. The facility is not in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review the facility failed to ensure call lights are within reach for 2 of 20 sampled residents (Residents #2 and #10). The findings included: 1. Record review for Resident #10 revealed the resident was admitted to the facility on _____ with diagnoses that included in part the following: Left _____ and _____ Following _____ Affecting Unspecified Side, _____ and _____ (Generalized). The Minimum Data Set assessment dated _____ documented in Section C a Brief Interview of Mental Status score of 15, indicating a _____ response. On _____ at 9:15 AM an observation was made of Resident #10 sitting up in bed with the call light draped behind the _____ of the bed and	F 558	F558 Call lights for resident #2 and #10 were placed within reach of the residents. Audit of 100% of residents that their call lights were in reach Educate 100% of staff to place call lights within reach of residents Call light observation audits to be performed by DON or designee 5 times per week for 30 days, and then monthly ongoing. DON or designee to report findings of call light observation audits to QAPI committee meeting monthly.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

/2025

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.

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F 558	<p>Continued From page 1 out of the reach of the resident.</p> <p>On _____ at 11:15 AM an observation was made of Resident #10 being assisted by a staff member while in bed. The call light continued to be in the same place, draped over the _____ of the bed and inaccessible to the resident.</p> <p>On _____ at 12:00 PM an observation was made of Resident #10 out of bed in the wheelchair. The call light continued to be in the same place, draped over the _____ of the bed and inaccessible to the resident.</p> <p>During an interview conducted on _____ at 9:18 AM with Resident #10 who was asked if he can use his call bell, he said yes but he cannot reach it, it is probably behind him somewhere. When asked what he does if he needs to call for assistance, he said he has a big _____ and will have to yell.</p> <p>An interview was conducted on _____ at 9:40 AM with Staff L, Registered Nurse (RN), who stated she has worked at the facility since _____. When asked about call lights, the RN stated the call bell is supposed to be within the reach of the resident at all times.</p> <p>An interview was conducted on _____ at 9:50 AM with Staff B, RN, who stated she has worked at the facility since _____. When asked about call lights, she stated they need to be _____ where the resident can reach it.</p> <p>2. Record review for Resident #2 revealed the resident was admitted to the facility on _____ with the most recent readmission on _____.</p>	F 558			

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F 558	<p>Continued From page 2</p> <p>with diagnoses that included in part the following: with Acute of Shaft of Left . . . , Subsequent Encounter for Closed with Routine Healing, Generalized , Difficulty in Walking, and History of Falling. The Minimum Data Set assessment dated documented in Section C a Brief Interview of Mental Status score of 4 indicating severe</p> <p>On from 8:30 AM to 8:40 AM an observation was made of Resident #2 constantly banging on her overbed table and yelling for help that she needed to go to the bathroom several times.</p> <p>On at 8:43 AM an observation was made of Staff M, Certified Nursing Assistant (CNA), going into the room to assist Resident #2. The resident's call light was clipped to the top corner of her pillow and the resident was unable to reach the call light.</p> <p>During an interview conducted on at 8:43 AM with Resident #2 the resident was asked about her call light and she just yelled at this surveyor to leave her alone.</p> <p>During a side by side observation conducted on at 8:44 AM with Staff M, CNA, she was asked if Resident #2 can use the call light. She looked for the call light and found it at the top of the bed hanging off of the bed. She then handed the call light to the resident and asked her if she could push it for assistance and the resident did push the call light and yelled at Staff M CNA, now are you going to help me.</p>	F 558			

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F 584 F 584 SS=D	Continued From page 3 Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after must maintain a temperature range of 71 to	F 584 F 584			

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F 584	<p>Continued From page 4 81°F; and</p> <p>§483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the residents have a right to a safe, clean, comfortable and homelike environment for 6 of 27 resident rooms observed in the facility.</p> <p>The findings included:</p> <p>1). On _____ at 9:20 AM an observation made in _____ A revealed the following:</p> <p>*The wall behind the bed, was noted to be unsmooth and peeling paint.</p> <p>*The standing fan across from the resident's bed was covered with dust and debris.</p> <p>2). On _____ at 11:30 AM an observation made in _____ revealed an uncovered fluorescent bulb in the entryway, inside of the room.</p> <p>3). On _____ at 11:40 AM an observation made in _____ revealed the following:</p> <p>* An uncovered fluorescent bulb in the entryway, inside of the room. * The A/C vents were covered with dust and debris. * The lightbulb in the bathroom was out. * Unpainted plaster on the bathroom wall, next to the soap dispenser *A leaky faucet in the bathroom sink.</p>	F 584	<p>F584/N110 Light bulbs replaced in _____ Light covers replaced in _____ and 24, 33 Standing fan cleaned in _____ Walls smoothed and painted in _____ Leaking faucet fixed in _____ and Call light pull cord removed from grab bar in _____ Resident room environmental rounds completed by Administrator and Maintenance Director Inservice Administrator and Maintenance Director on preventative maintenance rounds and correcting maintenance concerns Administrator or designee to perform resident room environmental rounds weekly for 30 days, and monthly ongoing. Administrator or designee to report findings of environmental rounds to QAPI committee meeting monthly</p>		

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F 584	Continued From page 5 4). On _____ at 11:30 AM an observation made in _____ revealed the following: *An uncovered fluorescent bulb in the entryway, inside the room. *A leaky faucet in the bathroom sink. *A call light pull cord wrapped around the grab bar in the bathroom. 5). On _____ at 10:50 AM an observation made in _____ revealed a missing light bulb in the entryway, inside the room. 6). On _____ at 11:15 AM an observation made in _____ A revealed an uncovered fluorescent bulb in the entryway, inside the room. A side-by-side tour of the facility was conducted on _____ at 10:20 AM with the Director of Maintenance who stated he has been at the facility for 1.5 weeks and the Administrator who started the week of survey. They acknowledged the above findings. The Administrator stated they will be working on the aforementioned items to get them corrected right away.	F 584			
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and _____, _____ needs that are identified in the comprehensive	F 656			

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F 656	Continued From page 6 assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and _____ well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. () In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and _____-informed. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews the facility failed to develop and implement a	F 656	F656 Resident #37 care plan updated for		

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F 656	<p>Continued From page 7</p> <p>comprehensive person-centered care plan for 1 of 1 sampled resident reviewed for (Resident #37) and failed to develop and implement a comprehensive person-centered care plan for 1 of 1 sampled resident reviewed for /Behavior (Resident #59).</p> <p>The findings included:</p> <p>1. Record review for Resident #37 revealed the resident was admitted to the facility on with diagnoses that included in part the following: Type 2 and Unspecified Abnormalities of Gait and Mobility. The Minimum Data Set assessment dated documented in Section C a Brief Interview of Mental Status score of 10, indicating moderate</p> <p>Review of the Physician's Orders for Resident #37 revealed an order dated for for cleanse with normal (N/S), dry, apply daily and PRN (as needed) every day shift was discontinued on</p> <p>Review of the Care Plan for Resident #37 dated with a focus on the resident has to related to Immobility. The goal was for the resident's will show signs of healing and remain free from by/through review date. The interventions included in part the following: Administer treatments as ordered and monitor for effectiveness. Assess/record/monitor healing. Measure length, width and depth where possible. Assess and document status of perimeter, bed and healing progress.</p>	F 656	<p>maintenance and Resident #59 care plan developed and implemented for medications. 100% audit of residents with medications and for development and implementation of care plans as identified. 100% Inservice of all licensed nursing staff for care plan development and implementation for and medications DON or designee to audit residents on medications and with for care plan development and implementation weekly for 30 days and monthly ongoing. DON or designee to report findings of care plan audits to QAPI committee meeting monthly</p>	

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F 656	<p>Continued From page 8</p> <p>Report improvements and declines to the MD. Follow facility policies/protocols for the prevention/treatment of _____ Monitor/document/report PRN any changes in skin status: appearance, color, _____ healing, signs/symptoms of _____ size, stage.</p> <p>In summary the review of the care plan for Resident #37 was not updated to indicate the _____ identified and did not indicate the _____ to the _____ had been resolved.</p> <p>In summary the facility acquired _____ was not updated on the care plan, additionally there were no interventions in place for Resident #37 to prevent the development of a _____.</p> <p>Review of the _____ Care Progress Note by the _____ Care Consultant company dated _____ documented in part the following: _____ location: _____, Length 4 centimeters (cm), Width: 3.2 cm, Depth: 0.2 cm. Status: Recurrent.</p> <p>During an interview conducted on _____ at 12:30 PM with the Minimum Data Set (MDS) Coordinator who stated she is the only MDS coordinator and has worked at the facility for 3 years and in the MDS department for about 3 months. The MDS Coordinator stated that the Dietary department, _____ department and the Social Worker all put in their own care plans, and she does all the nursing care plans. The MDS Coordinator stated she would update care plans as needed based on specific findings. When asked when a resident has a _____ or skin care plan and develop a new _____, would the care plan be implemented or updated, she said yes. When asked what the time frame is to</p>	F 656		

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F 656	<p>Continued From page 9</p> <p>update the care plan when there is a new she said if there is something new it should be updated within couple of days. When asked if there should be interventions in the care plan for prevention of skin issues or , especially if the resident has had a in the past, she said yes. The MDS Coordinator acknowledged she did not implement a care plan for the and that the care plan for the should have been resolved a long time ago.</p> <p>2. Record review for Resident #59 revealed the resident was admitted to the facility on with diagnoses that included in part the following: Degenerative of Nervous System, Restless Agitation, and . The Minimum Data Set assessment dated documented in Section C a Brief Interview of Mental Status could not be done due to the resident is rarely/never understood.</p> <p>Review of the Physician's Orders for Resident #59 revealed in part the following orders: An order dated for Oral Tablet 0.5 MG give 1 tablet by every 6 hours as needed for Agitation related to Restlessness and Agitation for 14 Days and was discontinued on .</p> <p>An order dated for Oral Tablet 25 MG give 1 tablet by one time a day for () related to Unspecified and was discontinued on .</p> <p>An order dated for Oral Tablet 25 MG give 25 mg by every 12 hours for .</p>	F 656			

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F 656	Continued From page 10 Review of the Care Plan for Resident #59 revealed there was no care plan for medications including interventions to monitor for behaviors or side effects. During an interview conducted on _____ at 9:30 AM with the Minimum Data Set (MDS) Coordinator who was asked if a resident who has _____ medications ordered would have a care plan, she said they should have a care plan for the _____ medication and include monitoring for behaviors and side effects. When asked about Resident #59, she acknowledged the resident had _____ medications ordered and no care plan in place.	F 656		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on review of policy and procedure, record review and interview, the facility failed to: 1) promptly notify the ordering physician and promptly administer oral _____ to a resident, in a timely manner, for a resident with a _____ () for 1 of 1 sampled resident (Resident #16); and, 2) failed to accurately document and assess the status and condition for a resident with a skin condition for 1 of 1 sampled	F 684	Resident #16 received ordered completed on _____ with no adverse effects. Resident #2 surgical site was dressed and documented on _____ with suture removal Audit of residents with surgical sites for documentation and care plan development and implementation	

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F 684	<p>Continued From page 11 resident (Resident #2).</p> <p>The findings included:</p> <p>1) Record review of the facility policy and procedure titled General Laboratory Information provided by the Director of Nursing (DON), reviewed 2024, documented in the Policy Statement: Communicating Urgent ResultsNotification will be provided to the Principal Investigator, Physician, or his/her authorized representative, as permitted or required by state and federal law, and these authorized personnel will have the responsibility of interpreting the result (s) in the context of the patient's clinical condition. The authorized personnel will be responsible for taking immediate action, if needed. If the authorized personnel are not qualified to make these decisions, he/she has the responsibility of communicating the information to a qualified person immediatelyAll critical results are called in to the facility, three attempts are made to communicate with resident's nurse, DON or unit manager. If unable to communicate verbal results, Biogalax will send an "Urgent Fax" memo. The "Urgent Fax" form will state the Name, DOB of the patient and 'Attention to Nurse, DON or Unit Manager.' All critical results must be reported to nurse, DON, or unit manager at facility</p> <p>Record review revealed Resident #16 was re-admitted to the facility on _____ with _____ diagnoses which included _____, Type 2 _____ with Complications, _____ and _____, and a History of Recurrent _____. He had a Brief Interview Mental Status (BIM) score of 15, indicative of intact cognition.</p>	F 684	<p>Audit of residents with current orders for _____ for completion of physician notification and prompt start of _____ if indicated.</p> <p>100% Inservice for all licensed nurses on _____ results with prompt physician notification and prompt start of ordered treatment</p> <p>100% Inservice for all licensed nurses for documentation of surgical sites and care plan development and implementation for surgical sites</p> <p>DON or designee to audit weekly for prompt notification of _____ results to physician with prompt start of ordered treatment and surgical site documentation with care plan development and implementation.</p> <p>DON or designee to report findings of all audits to QAPI committee meeting monthly.</p>		

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F 684	<p>Continued From page 12</p> <p>Review of Resident #16's record documented that the Physician's order had not been entered and uploaded into the facility's computer system by Staff I, a Licensed Practical Nurse, (LPN), until Wednesday at 7:35 PM. Furthermore it was not translated and captured in the system, until later the next day on Thursday and read as such: " Oral Capsule 100 mg (Macro) to give one (1) capsule by () two (2) times a day for () for ten (10) days," as ordered by the resident's current primary care physician PCP.</p> <p>There had also been two (2) different previously entered computerized physician's orders which indicated for: 1) and Culture dated Monday ---"one time only for for one (1) day." And, 2) dated Wednesday ---"one time only for for three (3) days."</p> <p>Next, computerized record review of the nursing progress notes entered by Staff I, a Licensed Practical Nurse, (LPN) documented that, on Wednesday at 07:03 AM, "Per outgoing nurse report resident has labs andUnable to collect this shift even after enforcing extra fluid intake. Tried several times, but remained unsuccessful due to patient in adult briefs by the time this writer had gone to him four (4) times. Oncoming nurse will be made aware. Collection cup left at bedside. tubing, specimen envelope and requisition, will be given to relieving nurse." Staff I, also documented on Thursday at 06:15 AM, " + drawn and picked up yesterday</p>	F 684			

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F 684	<p>Continued From page 13</p> <p>results remain pending. Oncoming nurse will be made aware"</p> <p>Further record review of the Laboratory Report for Resident #16 dated revealed that Resident #16's specimen for (E-) had been previously collected on Tuesday , received, resultd and reported on Thursday at 5:43 PM.</p> <p>Additional computerized record review was conducted of the two (2)---a) Physician Progress note dated at 01:00 AM by Resident #16's PCP documented "Nursing has concerns regarding change in mental status, but patient appears to be at baseline mental status , CMP, ammonia, A1C ordered for and b) Physician Progress note dated at 01:00 AM by Resident #16's PCP documented "including change in mental status", "Change in Mental Status () Workup initiated: , CMP, ammonia, , UA/UCx. Continue frequent mental status monitoring." As well as, progress notes documented by the Resident's Physician Assistant's (P.A.)'s, progress note visit entered on Tuesday , revealed that the abnormal culture results had been first identified and discovered by the P.A.", who in turn documented the following entry in the facility record, " with new + E- . Will start 100 mg x ten (10) days"</p> <p>There was no documentation noted in the nurses' progress notes dated from Wednesday at 07:03 AM through at 06:59 AM, to indicate if, when or what time the ordering physician had been notified of these abnormal culture results, by the facility.</p>	F 684			

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F 684	<p>Continued From page 14</p> <p>However, further review of Resident #16's Medication Administration Record (MAR), documented for the 100 mg was not started until Thursday at 09:00 AM, which is approximately one week after the lab results were reported to the facility.</p> <p>On at 06:59 AM, Staff I, also documented, " Diagnosis: with to be started this morning as ordered x 10 days (until Wednesday). Medication received this morning from pharmacy"</p> <p>A brief telephone interview was conducted on at 2:06 PM with the a supervisor at the Diagnostic laboratory to clarify the date and time the facility received the results was at 5:43 PM. He state he would speak with someone and get to this surveyor, however, there was no response received during the survey.</p> <p>A telephone interview was attempted on at 2:22 PM with Resident #16's Physician's Assistant/PCP, in order to ascertain whether or not the physician's office had been notified of Resident #16's abnormal and culture result of (E-), by the facility. This Surveyor left a voice message. However, there was no response received during the survey.</p> <p>A telephone interview was conducted on at 9:33 AM with Staff I, in order to ascertain whether or not Resident #16's "abnormal" culture results had been promptly reported to the ordering physician. Staff I also acknowledged that the "abnormal" culture lab work had previously been collected on , and</p>	F 684		

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F 684	<p>Continued From page 15</p> <p>reported to the facility on at 5:43 PM, per the lab report. When asked, did you document in the resident's record that you promptly notified the resident's ordering physician of the abnormal culture result, she responded, by saying that, "another nurse may have." And Staff I was also asked if she knew why there had been a seven (7) day delay between receiving Resident #16's "abnormal" culture lab work and in Resident #16 finally receiving his oral . Staff I responded by saying that, she was not working that whole time and she did not know. However, Staff I, acknowledged that the next nurse should have followed up to find out if the lab results had been obtained so that the resident could have received proper treatment, as indicated.</p> <p>During an interview conducted on at 3:22 PM with the DON, she was also asked to describe the process that occurs when an abnormal lab result report comes in, and who would be responsible for notifying the Physician of this and where would it be documented. The DON responded by saying that, "the laboratory would call the facility directly, whenever there was an "abnormal or critical" lab result. And, she said that the lab would ask to speak to a nurse, take his or her name, and would then fax over the "abnormal" lab result to the main fax machine located on the West wing across from the nurses' station, at the facility. Then, the DON said that the "assigned nurse" would be responsible for reaching out and contacting the ordering physician ASAP, with the "abnormal" lab results. Next, the DON indicated that the responsible nurse would "initial" the result, note that the Physician was notified, and would place the "abnormal" lab result in the box, located at the</p>	F 684			

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F 684	<p>Continued From page 16</p> <p>nurses' station, to be uploaded into the system the next morning, by their medical records department. The DON ended by acknowledging that there was no book or tracking log, at this time, in place to record and store the resident's "abnormal" lab results, in the facility.</p> <p>Staff member J, a Registered Nurse (RN), who had been working on Thursday at 5:43 PM, when the lab result was reported in from the lab, was no longer working with the facility and unavailable for an interview.</p> <p>There was no care plan on file specifically for " " care, for this resident.</p> <p>In fact, the physician notification and subsequent order for Resident #16's oral had not been performed nor obtained prior, by the facility. The physician's order for treatment was not initiated, with an intervention until five (5) days later, after it was first discovered by the Physician's Assistant.</p> <p>In Summary, the oral had not been started and administered to Resident #16 until seven (7) days after the "abnormal" lab results had been reported to the facility by the laboratory.</p> <p>The DON further recognized and acknowledged on at 3:30 PM that facility nursing staff, should have followed through with promptly notifying the ordering physician and she also indicated that there should not have been a delay of seven (7) days between the facility having received an "abnormal" culture result and for Resident #16 finally having received his ordered oral for treatment.</p>	F 684			

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F 684	<p>Continued From page 17</p> <p>2) Record review of the facility policy and procedure titled "Non-Sterile" provided by the Director of Nursing (DON), reviewed, documented in the Policy Statement: This procedure may involve potential/direct exposure to air contaminants, and hazardous chemicals. Purpose: The purposes of this procedure is to provide guidelines for non-sterile changes to protect from injury and to prevent the introduction of . Steps in the Procedure: ...15. Observe the and surrounding skin ...Reporting and Documentation: The following information ...be documented in the resident's electronic record medical record: 1. The date and initials of the person that performed the procedure. 2. Type of used and care give.....</p> <p>Record review revealed Resident #2 was re-admitted to the facility on with diagnoses which included of Shaft of Left , Subsequent Encounter for Closed with Routine Healing, Unspecified and Generalized . She had a Brief Interview Mental Status (BIM) score of 5, indicating severe .</p> <p>During an observational tour conducted on at 11:03 AM, Resident #2 was observed, her left pant partially pulled up, with a "partially attached" located on her left upper front area with two (2) "exposed and uncovered" noted underneath. And, upon closer observation of Resident #2's left just above her left , she was observed to have four (4) additional "exposed and uncovered" noted. Photographic Evidence Obtained.</p>	F 684			

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F 684	<p>Continued From page 18</p> <p>Resident #2 was asked, "in general" if she had any _____, at this time and she replied, "yes, sometimes she has an intermittent "pressure" type _____ from the top of her left _____ to her upper left _____ level _____, for which she gets medication for. It was noted that the edges of both _____ with _____ were well approximated, with no redness or drainage noted, at this time.</p> <p>Record review of the current physician's orders dated _____ documented, "Left lower extremity: Clean surgical site with normal (N/S), _____ dry, apply Xeroform, cover with protective _____ daily."</p> <p>Record review of Resident #2's re-admission note dated _____ documented, ".... Left _____ behind left _____ from the _____...Skin is warm and dry to touch.</p> <p>However, further record review of all subsequent nursing progress dated from _____ until _____, makes no mention of the existence, presence, current status nor current condition of Resident #2's "exposed and open to air" or surrounding skin, on her left lower _____, nor on the upper portion above her left _____.</p> <p>An additional record review of a progress note dated _____ by Staff K, an RN, in which it was documented, "Resident left _____ changed: cleanse with N/S, _____ dry, apply Xeroform, cover with protective _____ dry and clean no sign of _____ noted, no _____ redness, drainage noted, no complaints of _____ Treatment in place will continue to monitor." Again, there was no mention of the existence, presence, current status nor</p>	F 684			

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F 684	<p>Continued From page 19</p> <p>current condition of Resident #2's _____ or surrounding skin on her left lower _____, nor on the upper portion above her left _____.</p> <p>During a subsequent observation conducted on _____ at 11:04 AM, Resident #2 was now observed with three (3) _____, all initialed and dated _____, with one (1) located on the area above her left _____, a second one located to the resident's left upper and a third one located on the resident's lower outer front _____ area covering the previously seen " _____," of the two (2) upper skin _____ areas. Photographic Evidence Obtained.</p> <p>During a brief interview conducted on _____ at 11:04 AM with Resident #2's assigned nurse Staff L, RN, she stated that all three (3) _____ had been changed earlier that morning by Staff E, an RN, and by the Assistant Director of Nursing (ADON).</p> <p>An interview was conducted on _____ at 2:45 PM with the ADON, in which she acknowledged that she did assist Staff E, during the _____ change to Resident #2's left lower _____ earlier that morning at 7 AM, and she acknowledged that Resident #2 did have _____ in place in her left lower _____ at various locations. The ADON also acknowledged, as recorded in the resident's Treatment Administration Record (TAR) dated _____, and _____, that Staff K had also initialed that she had done the _____ changes to the left lower extremity for Resident #2. However, she also stated and noted that neither Staff K, nor Staff E, had documented anything regarding the existence, presence, current status nor current condition of Resident #2's _____ or surrounding skin on her left lower _____, nor on the</p>	F 684			

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F 684	<p>Continued From page 20</p> <p>upper portion above her left _____, in Resident #2's record for the date of _____.</p> <p>There was no care plan "specifically" _____ Resident #2's surgical _____ and _____.</p> <p>Moreover, there was no record of the nursing progress note for the _____ change performed on _____ at 7 AM, for this resident's left lower _____.</p> <p>Record review was also conducted of the TAR for the dates of Monday _____, Tuesday _____ by Staff K, and for the date of Wednesday _____ by Staff E, RN, Staff nurse, who performed the left lower _____ change, all indicated with "initials" that the _____ had been done and the physician's order was: "Left lower extremity: Clean surgical site with N/S, _____ dry, apply Xeroform, cover with protective _____ daily one time a day - Start Date Monday _____ at 0800 AM."</p> <p>Nonetheless, there had still been no mention of the existence, presence, current status, nor current condition detailing Resident #2's _____ or surrounding skin on her left lower _____ and on the upper portion above her left _____, anywhere in the resident's record for either of these three (3) above dates.</p> <p>The DON recognized and acknowledged on _____ at 3:14 PM, that the resident's complete skin status, including her _____, should be assessed and should have been documented in detail in the resident's record.</p>	F 684			
F 686 SS=D	Treatment/Svcs to Prevent/Heal CFR(s): 483.25(b)(1)(i)(ii)	F 686			

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F 686	<p>Continued From page 21</p> <p>§483.25(b) Skin Integrity §483.25(b)(1)</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that-</p> <p>(i) A resident receives care, consistent with professional standards of practice, to prevent _____ and does not develop _____, unless the individual's clinical condition demonstrates that they were unavoidable; and</p> <p>(ii) A resident with _____ receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent _____ and prevent new _____ from developing.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, interviews and record review the facility failed to ensure that a resident receives care, consistent with professional standards of practice, to prevent _____ and does not develop _____ for 1 of 1 sampled resident reviewed for, (Resident #37).</p> <p>The findings included:</p> <p>Record review for Resident #37 revealed the resident was admitted to the facility on _____ with diagnoses that included in part the following: Type 2 _____, and Unspecified Abnormalities of Gait and Mobility. The Minimum Data Set assessment dated _____ documented in Section C a Brief _____</p> <p>Interview of Mental Status score of 10, indicating moderate _____</p> <p>Review of the Physician's Orders for Resident #37 revealed in part the following orders:</p>	F 686	<p>F686</p> <p>Resident #37 orders updated for turning and repositioning every 2 hours as tolerated to allow for CNA documentation and care plan developed and implemented for _____ for 100% audit with _____ for turning and repositioning documentation and care plan development and implementation. Inservice 100% of licensed nurses on turning and repositioning order entry for CNA documentation and care plan development and implementation for _____</p> <p>DON or designee to audit orders for turning and repositioning to allow documentation by CNAs and care plan development and implementation for _____ 2 times weekly for 30 days, and then monthly ongoing. DON or designee to report findings of audits to QAP) committee meeting</p>		

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F 686	<p>Continued From page 22</p> <p>*An order dated Weekly skin assessment every Tuesday 7:00 AM to 7:00 PM Shift.</p> <p>*An order dated for cleanse with normal (N/S), dry, apply daily and PRN (as needed) every day shift was discontinued on</p> <p>*An order dated : Cleanse with N/S, dry, apply daily and PRN (as needed) every day shift for</p> <p>*An order dated for air mattress.</p> <p>*An order dated to encourage resident to turn and reposition frequently.</p> <p>Review of the TAR (Treatment Administration Record) for the month of had no documentation of care to the was provided on</p> <p>Review of the Progress Notes for Resident #37 from to revealed no documentation of turning or repositioning the resident nor was there documentation of the resident refusing to be turned and repositioned.</p> <p>Review of the Care Plan for Resident #37 revealed no care plan for the or prevention of</p> <p>Review of the Care Progress Note by the Care Consultant company dated documented in part the following: location: , Length 4 centimeters (cm), Width: 3.2 cm, Depth: 0.2 cm. Status: Recurrent.</p>	F 686	monthly.		

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105009	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/10/2025
NAME OF PROVIDER OR SUPPLIER GOLFCREST NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 600 NORTH 17TH AVE HOLLYWOOD, FL 33020	
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F 686	<p>Continued From page 23</p> <p>An interview was conducted on _____ at 11:05 AM with the Assistant Director of Nursing (ADON) who stated she has worked at the facility or 1 year. When asked how do you identify if a resident is high risk for development of _____, the ADON stated by doing a _____ screening and _____ assessment and history of resident. They are done on admission, depending on the score of the screening or assessments it will populate to reassess the resident. If the resident is high risk when it would populate for a reassessment again but does not know the exact time frame for the reassessment to be completed next. When asked about Resident #37, the ADON stated the resident had a _____ screening done on _____ that documented a score of 7 indicating less than 8 not high risk for developing a _____. On _____ the resident had a _____ Predicting _____ Risk documenting a score of 17 indicating at risk for developing a _____</p> <p>The ADON verified the resident had an order dated _____ for skin checks every Tuesday 7:00 AM to 7:00 PM shift. The licensed nurse weekly skin observation were completed on _____, and _____. The ADON acknowledged the weekly skin checks were not performed weekly as ordered.</p> <p>The ADON then stated on _____ documented in an Exception report was _____ however she believes this was documented as _____ in error and should have been a _____. The documentation on _____ of _____ as _____. When asked if the _____ care to the _____ was documented as performed on _____</p>	F 686		

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F 686	<p>Continued From page 24</p> <p>as ordered, the ADON acknowledged there was no documentation of the care being performed.</p> <p>An interview was conducted on _____ at 10:30 AM with Staff A, Certified Nursing Assistant (CNA), who stated she has worked at the facility for 7 years. When asked does she turn and reposition residents and if so how often, she said they turn and reposition residents every 2 hours. When asked where she documents the turning and repositioning, she said they do not have a place for her to document this in the electronic medical record.</p> <p>An interview was conducted on _____ at 10:45 AM with Staff B, Registered Nurse (RN), who stated she has worked at the facility since 2020. When asked what interventions the facility uses to prevent _____ or _____ she said they do weekly skin check and turn and reposition the resident's every 2 hours. When asked where this is documented, she said the weekly skin assessments are documented in the Weekly Skin Check Assessment. When asked about the documentation for turning and repositioning, she said only if there is an order they are documented on the TAR (Treatment Administration Record) or they can document on a progress note.</p> <p>During an interview conducted on _____ at 1:30 PM with the Director of Nursing (DON) who was asked about Resident #37 and she stated some nurses had documented a _____ but not any measurements or staging, she said this may have been documented incorrectly, because all of the orders for treatment were for _____ at the time</p>	F 686			

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F 686	Continued From page 25 when this documentation was in effect in late to early . The 3008 form from the transferring hospital dated documented skin condition of and as having road . The DON acknowledged there was no evidence in the resident's medical record that she had a on her while at the facility. The DON provided a statement on letterhead signed by her and dated "Resident #37 does not have any history of , on her ." During a telephone interview conducted on at 1:45 PM with the Advanced Registered Nurse Practitioner (ARNP) from the care company who was asked about the documentation of the care for Resident #37 dated , she said she put recurrent because that is what the DON had told her that the resident had a in the past. She stated this was the first time she had seen the resident, and she did not review the chart, she just documented based on what the DON had told her.	F 686			
F 693 SS=G	Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Nutrition (Includes naso- and tubes, both endoscopic, and fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by	F 693			

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F 693	<p>Continued From page 26</p> <p>methods unless the resident's clinical condition demonstrates that feeding was clinically indicated and consented to by the resident; and</p> <p>§483.25(g)(5) A resident who is fed by means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of feeding including but not limited to</p> <p>abnormalities, and</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, interviews, and record reviews, the facility failed to provide nutritional assessments and interventions in a timely manner which resulted in significant loss for 1 of 1 sampled resident (Resident #51); The facility also failed to follow Physician's orders for 2 of 5 sampled residents (Resident #167 and Resident #169).</p> <p>The findings included:</p> <p>A review of the facility's policy titled "Weighing and "at-risk" Protocol" and revised in showed the following:</p> <p>Nursing to complete all with on the following parameters: 0- variances of - loss or gain.</p> <p>Identification: When all (weekly and monthly) are completed, the Dietary Department will review for significant loss and "at risk" loss and determine variances with as noted above. The Dietary Department will notify nursing staff of significant and "at risk" residents the next day during the morning meeting. Investigation: The Dietary</p>	F 693	<p>F693</p> <p>Resident #51 was sent to hospital on . Resident #51 remains in hospital as of .</p> <p>Resident # 167 and #169 orders for feeding were clarified and corrected on</p> <p>100% audit of all feeding residents for orders to meet nutritional needs, one order and RD documentation. Inservice DON and Registered Dietician of documentation and feeding order requirements</p> <p>DON or designee to audit for feeding orders and RD documentation with feeds weekly times 4 weeks and then monthly ongoing.</p> <p>DON or designee to report findings of audits to QAPI committee meeting monthly.</p>	

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F 693	<p>Continued From page 27</p> <p>Department and nursing staff begin investigating loss: Is the Resident assisted with eating? Is Staff assisting with eating appropriately? Giving enough time? Does the Resident like food? Have food preferences? Family involved in bringing food? Intervention: Notify Dietitian of newly identified significant loss. Review intakes at a minimum weekly. Documentation: Dietary will document within 72 hours of investigation. Dietary to document monthly until resolved. Review weekly with nursing and dietary until loss resolved. Keep minutes of the meetings. Resident reviewed, and interventions initiated on all residents with significant loss and "at risk."</p> <p>A review of the American Society for Parental and Nutrition titled "Standards for Specialized Nutrition Support for Adult Residents of Long-Term Care Facilities" dated showed the following: Monitoring and Re-evaluating the Nutrition Care Plan, Parameters and Frequency: The frequency of monitoring should depend on the severity of illness, degree of stress, and level of stress. Daily or more frequent monitoring should be required in residents who are critically ill, have unstable debilitating or complications, are transitioning between feeding and oral diet, or have experienced complications. https://aspenjournals.onlinelibrary.wiley.com/doi/10.1177/011542650602100196.</p> <p>A record review showed that Resident #51 was admitted to the facility on and readmitted to the facility on with diagnoses of and type 2</p>	F 693			

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F 693	<p>Continued From page 29</p> <p>from 03/05/2025 to 4/8/2025, which indicates a 5.9% weight loss in a month.</p> <p>From 08/29 to 10/04 (36 days), severe weight loss of 6.7%.</p> <p>From 08/29 to 11/05 (67 days), showed a severe weight loss of 8.37%</p> <p>From 09/16 to 12/11 (3 months), showed a severe weight loss of 11.18%</p> <p>Resident #51 had an overall significant trending weight loss of 25.2% from 08/15/2024 to 04/08/2025 (past 8 months).</p> <p>The monthly weight taken on 4/8/25 was due to this Surveyor's intervention in attempting to obtain a monthly weight before Resident #51 left for the hospital.</p> <p>A chronological review of the orders indicated the following:</p> <p>In August 2024: Enteral Feed Order Glucerna 1.5 tube feeding at 60 ml per hour for 20 hours at 2:00 PM and off at 10:00 AM. This started on 08/30/2024 and was discontinued on 09/16/2024.</p> <p>In September 2024: an order was placed for enteral feed two times a day Glucerna 1.5 tube feeding at 60 ml per hour for 12 hours on at 7:00 PM and off at 7:00 AM. This started on 09/16/2024 and discontinued on 09/18/2024.</p> <p>An order was placed for enteral feed every night shift Glucerna 1.5 tube feeding at 60 ml/hr. for 12 hours on at 6:00 PM and off at 6:00 AM. This started on 09/18/2024 and discontinued on</p>	F 693			

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F 693	<p>Continued From page 30 12/09/2024.</p> <p>From 9/16/24 to 10/18/24, Resident #51 was only on tube feeding, which was not meeting her needs and was decreased from 20 hours to 12 hours a day on 09/16/2024.</p> <p>In October 2024, an order was placed for an enteral feed every night shift, Glucerna 1.5 tube feeding 60 ml per hour for 12 hours at 6:00 PM and off at 6:00 AM. This started on 09/18/2024 and was discontinued on 12/09/2024.</p> <p>An order was placed for a no-add-salt, low-concentrated sweet diet, mechanical soft texture, regular/thin consistency, and fortified foods for all meals, which started on 10/18/2024 and was discontinued on 12/9/2024.</p> <p>In December 2024, an order was placed for a regular, no-added-salt diet with a puree texture and nectar-thick consistency and no fortified food from 12/10/2024 to 01/13/2025.</p> <p>In January 2025, several orders were placed: from 01/13/25 to 01/15/25, a regular no-added-salt diet with a mechanical soft texture; from 01/15/25 to 01/15/25, a no-added-salt diet and low-concentrated sweet diet with a mechanical soft texture; from 01/16/25 to 02/06/25, a regular no-added-salt diet with a mechanical soft texture; and from 01/15/2025 to 03/19/2025, an order for Boost twice a day.</p> <p>In February 2025: an order was placed for enteral feed two times a day Jevity 1.5 at 50 ml/hr. for 12 hours, to be run until 600 ml infused, on at 6:00 PM and off at 6:00 AM which started on 02/06/2025.</p>	F 693			

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F 693	<p>Continued From page 31</p> <p>An order was placed for a regular diet mechanical soft texture on .</p> <p>An order was placed to add fortified foods with all meals on .</p> <p>A review of the orders indicated that Resident #51 spent 54 days (from to) only being fed by with no order of feeding. Further review showed a second decrease in the tube from 60 ml/hr. to 50 ml/hr. from .</p> <p>A review of the Dietary progress note dated (the day after Resident #51 got readmitted to the facility from the hospital) revealed the following: The Registered Dietitian stated that Resident #51 estimated needs were 1825-2190 kilocalories, 73-88 grams of protein and 1825-2190 milliliters(ml) of fluids. Resident #51 was put on pleasure feeding of pureed/thin and tolerated the well with no issues. The Dietary progress note further revealed an order clarification to 1.5 (formulary) at 60 ml x 20 hours (hrs.), flush with 50 ml for 20 hours, providing 1800 kilocalories (kcal), 99 grams (G) of Proteins and 1911 milliliters of total fluids, which will be meeting the lower end of the resident caloric needs and meeting over 100% of proteins.</p> <p>A review of the Dietary progress note dated (135 days after the previous Dietary progress note) revealed the following: The Registered Dietitian stated that Resident #51 and has a normal () of 23.4 for . The progress note further indicated that Resident #51</p>	F 693			

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F 693	<p>Continued From page 32</p> <p>loss was likely due to the transition from _____ to per oral with variable intake. A recommendation of: Boost 1 can (240 ml) by 2 times a day and fortified cereal at Breakfast with a diet of no added salt (NAS), mechanical soft, thin liquids were put in place.</p> <p>A review of the Dietary progress note dated _____ (the day after the 5.1% loss was identified) revealed the following: The Registered Dietitian stated that Resident #51 had significant loss _____ respectively for 1 month: 5.1%, 3 months: 11.8% and 6 months: 21.6% with a normal _____ for the _____ and a _____. Further review showed a recommendation to discontinue: No added salt restriction, clarify diet to a regular, mechanical soft texture, thin liquids, and fortified food with meals. A re-estimation of the needs based on current _____ indicated Kcal: 1770-2065, Protein: 59-77g, Fluids: 1770-2065 ml. A recommendation to re-start nocturnal feeds was placed with Jevity 1.5 (_____ formulary) at 50 ml per hour for 12 hours, run until 600 ml infused via _____ tube (_____) (on 6 PM, off 6 AM), water flush at 40 ml/hr and for 12 hours, run until 480 ml infused via _____ (on 6:00 PM, off 6:00 AM). It will provide 900 kcal, 38g protein, 936 ml free water, and 1080 ml total fluids. The new recommendation of _____ will be missing 870 kcal, 21g of protein, and 690 ml of fluids to meet the lower end of Resident #51's nutritional need, which would be provided from the diet intake by _____ (PO).</p> <p>A review of the Dietary progress note dated _____ revealed the following: The Registered Dietitian (RD) stated that Resident</p>	F 693		

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F 693	<p>Continued From page 33</p> <p>#51 and had a of 22.5 on , which indicated loss resolved due to a 1- gain since</p> <p>A recommendation was made to continue a no added salt diet with a mechanical soft texture and thin liquid PO. The RD further stated that Resident #51's intake varies from 25% to 75%. A recommendation is to continue supplemental feeds of Jevity 1.5 at 50 ml per hour for 12 hours starting at 6:00 PM daily until 600 ml has been infused (900 kcal and 42.5 grams of protein and 450 ml of free water). A review of the progress note further revealed a of Resident #51 nutrient and hydration needs with PO diet and regimen: Energy need:1500-1800 kcal, Protein needs:60-72 grams, and Fluid needs:1500-1800 ml. This indicates that the feeding of 900 kcal, 42.5g of protein, and 450 ml of free water is not meeting the Resident's nutritional and hydration needs. The RD also stated that the regimen is well tolerated, with no signs and symptoms of distention/cramping, fluid overload, or</p> <p>A review of the doctors' progress note dated indicated under the treatment section and sub-section of attention to tube a recommendation of 1.5 at 60 ml per hour for 20 hours at 2 PM and off at 10 AM. A review of the orders showed that this recommendation was never placed in the orders.</p> <p>A review of the care plan initially dated and revised on stated that Resident #51 is at risk for nutritional and hydration problems. Risk related to nocturnal as a supplement route of nutrition and hydration associated with Cerebro</p>	F		

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F 693	<p>Continued From page 34</p> <p>Accident. Medical diagnoses included failure, Essential Hypematremia, (), and (). Mechanical soft diet provided PO at all meals.</p> <p>A review of the past 30 days (from to) of the amount eaten showed various percentages of food intake for Resident #51: 16 meals between 0 and 25%, 13 meals between 26 and 50%, 51 meals between 51 and 75% and 8 meals between 76 and 100%.</p> <p>In an observation conducted on at 5:46 PM, Human Resources staff, Staff R, was seen setting up the tray and leaving the room right after. At 6:10 PM, the tray was still untouched; Resident #51 only ate the dinner roll and the cake. At 6:13 PM, Certified Nurse Assistant, Staff S, wrote 30% of the intake on Resident #51's meal ticket and took the tray out of the room.</p> <p>In an observation conducted on at 6:25 PM, Registered Nurse (RN) Staff T was seen writing Resident #51's information, including the start time (6:25 PM) on the bottle. After setting up the feeding, the Staff realized the was missing a "part" and called Registered Nurse Staff U for help. Staff T stated that she always sets up the for Resident #51 at night because during the day the Resident eats by</p> <p>In another observation conducted on at 6:40 PM, this Surveyor observed that the feeding started at 6:42 PM, but the monitor stopped and displayed an error message due to "clogs." After multiple attempts,</p>	F 693			

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F 693	<p>Continued From page 35 finally started at 6:50 PM.</p> <p>In an observation conducted on _____ at 5:40 AM, Resident #51 was awake in bed with no _____ bottle running or noted in the room. Staff V, RN, stated Resident #51 _____ all over the bed and she stopped the _____ at 5:30 AM. The bottle was about half full when she stopped it. Staff V stated that Resident #51 usually tolerates her _____ well with no issues.</p> <p>An order was placed on _____ to send Resident #51 to the Emergency Room for coffee ground _____ identified on _____.</p> <p>In an interview conducted on _____ at 8:00 AM, the Director of Nursing (DON) stated that specific staff members take the _____ on all residents, and the list is then given to Staff D, Medical Records, to put in the electronic system. Staff D calls the Registered Dietitian to discuss any _____ losses before recording them in the electronic system. The DON said Resident #51's _____ was taken on _____ but was not able to provide one and then said, "Maybe it was written on a piece of paper".</p> <p>In an interview conducted on _____ at 8:12 AM with Staff D, she stated she has two staff members who take the _____ on all residents, and the list is then given to her to record in the electronic system. The monthly _____ are taken on all residents from the 1st to the 5th of the month. If a resident has lost _____, the Registered Dietitian will ask for a reweigh to ensure the accuracy of the _____. For any weekly _____, the Registered Dietitian will provide her with a list of residents. When asked</p>	F 693			

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F 693	<p>Continued From page 36</p> <p>about the facility's policy for , Staff D stated residents' are taken on admission, once a week for 4 weeks, and monthly thereafter. For the monthly , the Registered Dietitian (RD) reviews all residents in the electronic system on a regular basis and will ask for a reweigh of any discrepancies. The RD comes to the facility once a week and has remote access as well to be able to assess the residents when not in the facility. When asked if the monthly was taken on Resident #51, Staff D said, "It might have slipped us a little bit" when we did all the monthly from the 1st to the 5th of this month.</p> <p>According to Staff D, the RD can see any significant/severe losses when she reviews the of all residents. If she sees any loss, she will notify the RD as soon as possible.</p> <p>In an interview conducted on at 11:00 AM, Resident #51's daughter (her caregiver) stated that she realized that her mother had lost a lot of and that she had been wanting to talk to someone. She said: "I've been lately because that's not my mom". Resident #51's daughter said her mother used to weigh between 200 and and that she is very concerned about the loss and how her mom looks now. Especially since she always attends all the care plan meetings and loss was never addressed or her preferences. She further explained that her mother doesn't like the food served in the facility, and that may be the reason why she only eats the sweets that are served. Resident #51's daughter stated that sometimes the Staff tells her that her mother eats 60% but doesn't believe it because her mother</p>	F 693			

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F 693	<p>Continued From page 37</p> <p>barely eats 30% when she is present, which is about 3 times a week.</p> <p>In an interview conducted on /1015 at 12:30 PM, the Registered Dietitian (RD) stated that she started working for this facility on and works between 15 to 20 hours a week and comes only on Fridays. RD explained that she sees the residents on Fridays when she comes and logs in every day to see new admissions. If a new resident is admitted with something "crucial" like , she calls the Director of Nursing and tries to do the assessment within 24 hours and after monthly. RD further explained that if a resident is on pleasure feeding, then the must meet all the resident's needs. A resident on is considered at high risk, and to take a resident off the one of the criteria is that the resident is consistently eating 75% or more. As for the , RD explained that she runs an "exception report" between last month and this month, which tells her what happened so she can make the necessary adjustments. RD did not adjust the for Resident #51 because Resident had a 1- gain and was waiting for the monthly to consider changes. When asked by this Surveyor if she visited Resident #51 or spoke to her daughter regarding food likes and preferences, she said no.</p> <p>The current facility Registered Dietitian did not reweigh Resident #51 or adjust the estimated needs of the Resident due to the 1- gain and did not consider the trending significant loss for the last 6 months.</p> <p>In an interview conducted on at 2:28 PM, the Director of Nursing (DON) stated that</p>	F 693			

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F 693	<p>Continued From page 38</p> <p>she had four different dietitians in 6 months. There was no dietitian coverage from to . The DON further explained that the expectation for a resident on is to be seen weekly by the RD, and if residents are stable, then the visits should be monthly. She also expected the RD to recognize the loss on Resident #51 and acknowledged that no RD notes were placed for Resident #51 from to (4 months).</p> <p>In an interview conducted on at 2:45 PM with a Registered Nurse, Staff E stated that she is familiar with Resident #51. She further stated that Resident #51 tolerates well and has been eating between 50% and 60% on average.</p> <p>In an interview conducted on at 3:00 PM with Medical Records, Staff D stated that she has been working at the facility for 6 years and is very familiar with Resident #51. Staff D explained that Resident #51 would drink a lot but only ate 25% more or less.</p> <p>In an interview conducted on at 2:25 PM with a Certified Nurse Assistant (CNA), Staff P stated that she is familiar with Resident #51 and that her food intake depends on the type of food. For example, for Breakfast, she will eat 50% some days, but for lunch and dinner, she wouldn't eat more than 25%. Staff further stated that Resident #51 is not a big eater, and that Breakfast is the best one for her.</p> <p>In an interview conducted on at 2:30 PM with the Registered Nurse, Staff Q stated that she is familiar with Resident #51. Staff Q explained that Resident #51 likes to drink (coffee,</p>	F 693			

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F 693	<p>Continued From page 39</p> <p>milk, and orange juice) more than eat. Her food texture changed on multiple occasions from pureed (because she did not want it) to regular texture. Once it was changed to a regular texture, Resident #51 started choking, so it had to be changed to mechanical chopped. Staff Q further stated that as the RN on the floor, the CNAs come to her and inform her of Resident #51's intakes. Breakfast is her best food, and she eats 50% of it.</p> <p>In an interview conducted on _____ at 2:10 PM, Resident #51's daughter (caregiver) stated that she is not happy with the _____ loss; her dad cried when he saw his wife at the hospital because she had lost so much _____. "That should have never happened in the first place, they should have never feeding my mom properly." The Resident's daughter further reported that the doctor at the hospital explained that her mother would never be able to eat by _____ again.</p> <p>2. Resident #167 was admitted to the facility on _____ with diagnoses of _____ Failure, and _____. A review of the Physician's order noted two overlapping orders for _____. If vital AF 1.2 (_____ formulary type) is not available, may substitute with Peptamen 1.5 (_____ formulary type) at 240 milliliters (ml) every 4 hours dated _____. Another order was noted for 20 hours at 10:00 AM and off at 2:00 PM. Feeding: Vital Advanced Formula, 1000ml, 55ml an hour, which was dated _____.</p> <p>A review of the Medication Administration Record showed that both above _____ orders were checked as administered in _____.</p>	F 693		

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F 693	<p>Continued From page 40</p> <p>In an observation conducted on _____ at 10:35 AM, Resident #167 was noted in bed with the _____ Peptamen 1.5 at 50ml an hour, which was dated _____, but no start time. The _____ was noted at the 750ml mark out of the 1000ml capacity bag.</p> <p>In an observation conducted on _____ at 3:30 PM, Resident #167 was noted in bed with the _____ Peptamen 1.5 at 50ml an hour, which was dated _____, but no start time. The _____ was noted at the 700ml mark out of the 1000ml capacity bag. This showed that only 50ml was administered in the last 1 hour and a half.</p> <p>In an observation conducted on _____ at 5:20 PM, Resident #167 was noted in bed with the _____ continuous Peptamen 1.5 at 50ml an hour, dated _____, and no start time. The _____ was noted at the 600ml mark out of the 1000ml capacity bag, which showed that 100ml was infused in the last 2 hours.</p> <p>In an observation conducted on _____ at 5:48 AM, Resident #167 was noted in bed with the _____ on hold. The _____ bag started at 5:00 AM on _____ and was at the 900ml mark out of a 1000ml capacity bottle.</p> <p>In an interview conducted on _____ at 1:00 PM with Staff F, the Registered Nurse stated she only realized this morning when she started her shift that Resident #167 had two _____ orders. She asked the Nurse supervisor to check the _____ orders and update them accordingly. Staff F acknowledged that both orders were checked as given in the MAR under each specific order.</p>	F 693			

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F 693	<p>Continued From page 41</p> <p>A review of the log revealed Resident #167's admission , dated . A new was obtained on as per this Surveyor's request, which showed Resident #167 was at , indicating a 2- loss.</p> <p>In an interview conducted on at 1:30 PM with Resident #167' son stated his father used to be around about a year ago and has been in and out of the hospitals for some time.</p> <p>The nutrition assessment dated showed the following: Resident #167's Ideal Body . He does not eat anything by , and his only route of nutrition and hydration is feeding. This assessment addressed the order of Vital AF 1.2 every 4 hours but not the continuous order of , with Vital Advanced Formula, 1000ml, 55ml an hour. Resident #167 was noted at and that the current order was meeting needs.</p> <p>A new order for 20 hours of feeding-Peptamen (formulary)1000ml,60ml, and hour, dated was noted.</p> <p>A review of the Care Plan showed Resident #167 has nutritional and hydration problems related to nothing by status and medical history. It further revealed that feedings and flushes should be provided as ordered.</p> <p>3. Resident #169 was readmitted to the facility on</p>	F 693			

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F 693	<p>Continued From page 43</p> <p>In an observation conducted on _____ at 5:20 PM, Resident #169 was noted in bed with the _____ Peptamen 1.5 at 60ml an hour, which was dated _____, but no start time. The _____ bag was noted at the 600ml mark out of a 1000ml capacity bottle. Only 200ml of formulary was administered in the last 5 hours, and not the necessary 350ml of formulary.</p> <p>In an observation conducted on _____ at 6:20 AM, Resident #169 was noted in bed with the _____ Peptamen 1.5 running at 60ml an hour. The bag had a start date of _____ with a start time of 5:00 AM. It was also noted at the 900ml mark out of a 1000ml capacity bag. In this observation, Staff G, a Registered Nurse, stated Resident #169 tolerated his _____ well. She further said that she started the _____ a little less and increased it to where it needed to be when Resident #169 was more elevated with his _____ on the bed.</p> <p>The Nutrition assessment dated _____ revealed the following: Resident #169 is at risk for _____ with a _____ % over the past 30 days, likely due to _____ dislodgement and replacement. The current _____ order of Peptamen 1.5 at 60ml an hour for 20 hours is meeting estimated needs.</p> <p>A follow-up nutritional note dated _____ showed Resident #169 had a _____ () of _____ status. The _____ regimen is adequate in nutrients to meet his current needs. The Clinical Dietitian _____ the energy and protein needs and recommended increasing the _____ regimen to 70ml an hour from 60ml an hour. This was not followed in the above</p>	F 693			

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F 693	Continued From page 44 observations.	F 693			
F 758 SS=D	Free from Unnec Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Drugs. §483.45(c)(3) A, drug is any drug that affects activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) ; (ii) ; (iii) ; and () . Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for drugs are limited to 14 days. Except as provided in	F 758			

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F 758	<p>Continued From page 45</p> <p>§483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.</p> <p>§483.45(e)(5) PRN orders for . . . drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interviews and record reviews, the facility failed to ensure adequate monitoring of side effects and behaviors for residents receiving . . . medications for 2 of 5 sampled residents reviewed for Unnecessary Medication (Resident #1); for 1 of 1 resident sampled residents reviewed for Behavior (Resident # 59); and failed to ensure adequate monitoring of side effects of residents prescribed (. . .) for 1 of 1 sampled residents reviewed for Unnecessary Medications (Resident #45).</p> <p>The findings included:</p> <p>1. Record review for Resident #59 revealed the resident was admitted to the facility on with diagnoses that included in part, the following: Degenerative of Nervous System Unspecified, Restless Agitation, and . . . The Minimum Data Set assessment dated . . . documented in Section C, a Brief Interview of Mental Status could not be done due to the resident is rarely/never understood.</p>	F 758	<p>F758</p> <p>Resident #45 had orders clarified for monitoring of side effects of</p> <p>Resident #1 and #59 had orders clarified for monitoring of side effects and behaviors for . . . medications Audit of 100% of residents with . . . for side effect monitoring Audit of 100% of residents with . . . medications for side effect and behavior monitoring Inservice all licensed nursing staff on orders with . . . to have side effect monitoring and orders with . . . medications to have side effect and behavior monitoring. DON or designee to audit for side effect monitoring and . . . meds for side effect and behavior monitoring weekly for 4 weeks and then monthly ongoing. DON or designee to report findings of audits to QAPI committee meeting monthly.</p>		

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F 758	<p>Continued From page 46</p> <p>Review of the Physician's Orders for Resident #59 revealed in part, the following orders:</p> <p>*An order dated for Oral Tablet 0.5 MG give 1 tablet by every 6 hours as needed for Agitation related to Restlessness and Agitation for 14 Days and was discontinued on .</p> <p>*An order dated for Oral Tablet 25 MG give 1 tablet by one time a day for () related to Unspecified and was discontinued on .</p> <p>*An order dated for Oral Tablet 25 MG give 25 mg by every 12 hours for .</p> <p>*An order dated for Side Effect Observation Order #2: 15-Appetite change/ change; 16- ; 17- ; 18-Akathisia-restlessness/pacing/inability to sit still/ /sleep disturbances; 19- Tardive dyskinesia-- , smacking/chewing/abnormal movement/spasmodic movement of arms/ -rocking/swaying; 20- abnormalities; 21- ; 22- ; 23-Photosensitivity; 24- ; 25- disturbances; 26- or abnormalities; and 27-Ataxia every shift for Behaviors.</p> <p>*An order dated for Side Effect Observation Order #1: 1-Dystonia, torticollis (stiffness of); 2- symptoms: dry /blurred vision, /retention; 3- ; 4- /drowsiness; 5-Increased / ; 6- .</p>	F 758			

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F 758	<p>Continued From page 47</p> <p>abnormalities (, irregular, H.R., NMS); 7- ,/agitation ; 8-Blurred Vision ; 9-Sweating/rashes ; 10- ; 11- retention/hesitancy ; 12- ; 13-Hangover effect ; and 14- every shift for Behaviors.</p> <p>*An order dated for Behavior Code 1 : Depressed / withdrawn - Document # of times behavior occurred each shift every shift for Behaviors</p> <p>An order dated for Behavior Code 1 : Depressed / withdrawn - Document # of times behavior occurred each shift every shift for Behaviors.</p> <p>*An order dated for Behavior Code 2 : Agitated - Intervention Codes: 1. One on one 2. Activity 3. Adjust room temperature 4. Backrub 5. Change position 6. Give fluids 7. Give food 8. Redirect 9. Refer to progress notes 10. Remove resident from environment 11. Return to . Toilet every shift for Behaviors.</p> <p>*An order dated for Behavior Code 3 : Agitated - Document Outcome Code: I-Improved ; S-Same ; W - Worsened every shift for Behaviors.</p> <p>In summary Resident #59 was ordered 2 separate medications (and) on and there was no order to monitor side effects or behaviors for these medications until .</p> <p>Review of the Medication Administration Record (MAR) and Treatment Medication Administration (TAR) for Resident #59 documented the resident had received the as ordered, and was</p>	F 758			

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NAME OF PROVIDER OR SUPPLIER GOLFCREST NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 600 NORTH 17TH AVE HOLLYWOOD, FL 33020		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 758	<p>Continued From page 48</p> <p>not administered the . . . There was no documentation of behavior or side effect monitoring until . . .</p> <p>Review of the Care Plan for Resident #59 revealed there was no care plan for . . . medications including interventions to monitor for behaviors or side effects.</p> <p>An interview was conducted on . . . at 9:40 AM with Staff L Registered Nurse (RN) who stated she has worked at the facility since . . . When asked about when a resident is receiving . . . medications do they monitor for behaviors and side effects, she said yes. When asked where this is documented she said on the MAR and if there is a behavior or side effect observed then you make a progress note.</p> <p>An interview was conducted on . . . at 9:50 AM with Staff B Registered Nurse (RN) who stated she has worked at the facility since . . . When asked about when a resident is receiving . . . medications do they monitor for behaviors and side effects, she said yes. When asked where this is documented she said on the MAR and if there is a behavior or side effect observed then you make a progress note.</p> <p>2. Record review revealed Resident #1 was admitted to the facility on . . . and readmitted on . . . with diagnosis of Acute Diastolic (. . .) and . . . due to an underlying condition. The quarterly Minimum Data Set (MDS) assessment dated . . . revealed</p>	F 758			

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F 758	<p>Continued From page 49</p> <p>that the Brief Interview of Mental Status () score was 3, which indicates severe</p> <p>A review of the physician orders indicated that Resident #1 had an order for Oral Tablet of 10 milligrams (mg.) once a day for dated:</p> <p>A review of a care plan dated indicated that Resident #1 is prone to side effects and changes in behavior, and cognition related to the use of medications. Observation and monitoring for potential changes in behaviors, and side effects such as rigid, appetite loss, dry, dry, fecal impaction, and gait changes are necessary.</p> <p>A review of the physician orders, Medication Administration Record (MAR) and the Treatment Administration Record (TAR) indicated that the facility failed to implement interventions to monitor changes in behavior, and potential side effects related to the use of medications for Resident #1.</p> <p>In an interview conducted on at 11:00 AM, Director of Nursing (DON) stated that they don't monitor and behaviors or side effects for medications because it's not part of the protocol that they follow.</p> <p>3. Record review revealed Resident #45 was admitted to the facility on and readmitted on with a diagnosis of, and. The Quarterly Minimum Data Set (MDS) assessment dated showed that Resident #45 had a Brief</p>	F 758			

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F 758	<p>Continued From page 50</p> <p>Interview of Mental Status () score of 11, which indicates moderate</p> <p>A review of the Physician's orders showed an order for (an medication): give one tablet, 2.5 milligrams, every 12 hours, for . No order was noted to monitor side effects or adverse effects of the above medication.</p> <p>A review of the Care Plan dated showed the following: Resident #45 is on , related to . Resident #45 will be free from discomfort or adverse reactions to use through the review date. It further showed to monitor/document/report adverse reactions of -tinged or red in , black tarry stools, dark or bright red in stools, sudden severe blurred vision, loss of appetite, sudden changes in mental status, significant or sudden changes.</p> <p>Further record review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) for Resident #45 did not show that the facility was monitoring the side effects and adverse reactions of the medication.</p> <p>In an interview conducted on at 10:47 AM with the Director of Nursing (DON), she stated that there should be a batch order to monitor the side effects of medication, and nursing should document this in the MAR and the TAR.</p> <p>In an interview conducted on at 10:51</p>	F 758			

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F 758	Continued From page 51 AM, Staff H, a Registered Nurse, stated Resident #45 was on an _____ and was being monitored for side effects such as _____ and _____. She then said it is documented in the MAR and the TAR and proceeded to show this Surveyor in the electronic system. She then responded to the surveyor and said, "It is not here."	F 758		
F 880 SS=D	Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Control The facility must establish and maintain an _____ prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable and _____. §483.80(a) _____ prevention and control program. The facility must establish an _____ prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling and communicable _____ for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 880		

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F 880	<p>Continued From page 52</p> <p>possible communicable or before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable or should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of ; ()When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable or skin from direct contact with residents or their food, if direct contact will transmit the ; and (vi)The hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on review of policy and procedure,</p>	F 880			
		F880			

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F 880	<p>Continued From page 53</p> <p>observation, interview and record review, the facility failed to wear or don appropriate personal protective equipment (PPE), preventing control, during high-contact resident care activity for 1 of 1 sampled resident observed for _____, Resident #171.</p> <p>The findings included:</p> <p>Record review of the facility policy and procedure titled Enhanced Barrier Precautions provided by the Director of Nursing (DON) reviewed _____ documented in the Policy Statement: Enhanced Barrier Precautions expand the use of PPE beyond situations in which exposure to _____ and _____ is _____ and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of Multidrug-resistant Organisms (MDRO) to staff and clothing</p> <p>Record review of the facility policy and procedure titled _____ Care, _____ provided the DON reviewed _____ documented in the Policy Statement: This procedure may involve potential/direct exposure to _____, _____, air contaminants, and hazardous chemicals. Protective Barriers that may be needed: ...Gown ...Purpose: The purpose of this procedure is to prevent _____ of the resident's _____ tract</p> <p>Record review revealed Resident #171 was admitted to the facility on _____ with diagnoses which included _____. She had a Brief Interview Mental Status (BIM) score of 00, indicating severe _____.</p>	F 880	<p>Care was provided to resident # 171 after gown was provided to staff N by staff O Inservice to nursing staff regarding Enhanced Barrier Precautions and donning gowns prior to care. DON or designee to do observational audits for Enhanced Barrier Precautions with gown donning prior to care 5 times weekly for 30 days and then monthly ongoing. DON or designee to report findings of audits to QAPI committee meeting monthly.</p>	

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F 880	<p>Continued From page 54</p> <p>A physician's order dated _____ documented for "Enhanced Barrier Precautions: _____ /biliary drain."</p> <p>During an observation conducted on _____ at 9:52 AM, of _____ care for Resident #171, it was noted that _____ care was being performed by Staff N, a Certified Nursing Assistant (CNA). Staff N was observed setting up, preparing and beginning to perform " _____ -on" and _____ care on this resident, while only wearing gloves, with no protective PPE gown on. During the start of this observation, Staff N was observed leaning over, and "in-close" proximity to the resident, whose peri-area with his _____, was visibly exposed. Staff N was subsequently "interrupted," by Staff Member O, a CNA, who reached inside of Resident #171's room door in order to _____ Staff N, a protective gown to wear. Upon inquiry by the surveyor, Staff N, was unable to provide a "clear" explanation, when asked, as to why she had begun pulling _____ the resident's covers, touching his person, re-positioning his _____ and proceeding to begin with the resident's peri- _____ care, without first donning a clean protective gown over her clothing, prior to performing this procedure, for Resident #171.</p> <p>On _____ at 10:17 AM an interview was conducted with Staff O, in which she was asked about why she was observed handing a protective gown through the resident's room door to Staff N, after peri- _____ care had already begun for this resident. Staff O acknowledged that she had done so because she noticed that Staff N, was not wearing one and she said that she should have been, since the resident had a</p>	F 880		

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F 880	Continued From page 55 , in place. During an interview on _____ at 2:17 PM, the DON (Director of Nursing), also functioning as the Control Nurse) stated that on _____ and _____, she had recently educated the nursing staff nurse on the importance of Control procedures, including appropriate PPE as well as handwashing and providing _____ care to the residents. The DON acknowledged that the CNA should have donned appropriate PPE gown, prior to performing _____ care for Resident #171. Photographic Evidence Obtained	F 880			