

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/05/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105462	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/07/2025
NAME OF PROVIDER OR SUPPLIER VIVO HEALTHCARE CLEWISTON			STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH GLORIA ST CLEWISTON, FL 33440		
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F 000	INITIAL COMMENTS An unannounced complaint survey for #2025004503 was conducted on at Clewiston Nursing and Rehabilitation, a skilled nursing facility in Clewiston Florida. Complaint #2025004503 was substantiated with citation at F600 and F689. Clewiston Nursing and Rehabilitation is not in compliance with Code of Federal Regulations (CFR) 42, Part 483, Subparts B-F, Requirements for Long-Term Care Facilities. The following is the description of the noncompliance.	F 000			
F 600 SS=G	Free from and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from , Neglect, and . The resident has the right to be free from neglect, misappropriation of resident property, and as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary and any physical or chemical not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, , or , corporal punishment, or involuntary ; This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to protect the residents' right to be	F 600	1. What corrective action(s) will be accomplished		

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 600	<p>Continued From page 1</p> <p>free from neglect for 1 (Resident #999) of 4 sampled residents by failing to ensure staff follow safety precautions while providing care to prevent avoidable and related major injury.</p> <p>The findings included:</p> <p>Review of the facility's neglect investigations revealed on at approximately 6:40 p.m., Certified Nursing Assistant (CNA) Staff A was providing care to Resident #999. The CNA turned the resident on his left side to remove his brief. The resident "moved more off the bed as she placed her on his side to hold him he went falling." The incident investigation noted Resident #999 sustained "a red discoloration to the right side of his and a on his right ". Resident #999 was transferred to a local hospital and diagnosed with an acute intra-axial (front of the () within the left frontal) measuring 2.0 by 1.07 by 2.4 centimeters.</p> <p>The investigation noted CNA staff A turned Resident #999 on his left side to remove his brief and bed sheet. As she was placing the fitted sheet on the bed she saw the resident "moving more off the bed" so she placed her on his side to hold him. The resident off the bed because his "was too heavy on one side." Once the resident "the floor" she went out into the hallway to get help.</p> <p>The investigation noted the nurse arrived in the room, observed Resident #999 on his right side with a hematoma (collection of outside the) on the right side of the</p> <p>As part of the investigation, on CNA Staff A demonstrated she had the resident centered and as she turned him, he was more toward the other</p>	F 600	<p>for those residents found to have been affected by the deficient practice:</p> <p>-On , , upon immediate discovery resident #999 was assessed, received first aid, and transferred to a higher level of care for further evaluation and treatment as indicated.</p> <p>-On , , investigation immediately initiated, Staff member A suspended pending the outcome of the investigation.</p> <p>-On , , staff member A along with the Executive Director performed a reenactment of the incident that resulted in a mechanical , it revealed the stakeholder failed to follow policy and performed toileting hygiene, which includes bed mobility independently.</p> <p>2.How you will identify other residents having potential to be affected by the same deficient practice and what corrective actions will be taken: -A quality review was performed on , by the Executive Director and DCS of all residents that reside in the facility in which staff</p>	

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F 600	<p>Continued From page 2</p> <p>side, away from her which resulted in the resident's falling as he moved.</p> <p>The facility verified the allegation of neglect and noted CNA Staff A would be terminated for failure to follow the facility's policy and procedures related to reviewing residents Kardex (System of communication and organization used in nursing that helps long term care facilities document resident care summaries).</p> <p>Review of the Kardex revealed to turn and reposition Resident #999 every two hours and as needed. The Kardex did not specify that the resident required the physical assistance of two persons for bed mobility, including turning and repositioning as per the Nursing Admission evaluation.</p> <p>Review of the staff education dated noted "Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, mental anguish or emotional distress."</p> <p>Review of the facility new employee education and in-service training revealed, " At the start of the shift, read the Kardex for updated changes such as interventions in place for bed mobility, transfer status, behaviors."</p> <p>Review of the clinical record revealed Resident #999 was a male with an admission date of . Diagnoses included right side (on one side of the body) and (of one side of the body) related to , and a history of .</p> <p>The Admission Minimum Data Set (MDS)</p>	F 600	<p>member A provided care to ensure no other residents sustained a due to improper bed mobility and free from or neglect. No discrepancies noted.</p> <p>-A quality review was performed on , by the Director/ DCS/UM of all residents that reside in the facility of their Kardex and Careplan ensuring that bed mobility was present and accurate.</p> <p>No noted discrepancies. The information was present, accurate and accessible to all nursing staff.</p> <p>3.What measures will be put in place or what systemic changes you will make to ensure that the practice does not recur:</p> <p>-On , and ongoing the nursing staff re-educated by the DCS/ Designee regarding the components of this regulation with the emphasis on the following: "Kardex use- ensuring the Kardex is reviewed and followed prior to providing care for the resident. " Bed mobility- ensure proper bed mobility is used to include but not limited to the correct number of people to complete the task and always roll a resident towards you never away. Ensure the proper number of people are present to perform the task</p>	

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F 600	<p>Continued From page 3</p> <p>assessment (standardized tool that measures health status in nursing home residents) with an assessment reference date of documented Resident #999 was dependent for bathing, toileting, personal hygiene and bed mobility (Helper does all of the effort, Resident does none of the effort to complete the activity). The MDS noted Resident #999's _____ skills for daily decision making were severely _____. Resident #999 was rarely/never understood. Review of the New Admission Re-Admission Evaluation form dated _____ revealed Resident #999 required the physical assistance of two persons for bed mobility. Resident #999 scored "18" on the risk evaluation upon admission indicating the resident was at high risk for _____. The care plan initiated on _____ identified Resident #999 had activity of daily living self-care performance _____ due to, "_____/decreased cognition, _____, and _____".</p> <p>The interventions noted the resident had an air mattress to his bed and was, "dependent with rolling left to right".</p> <p>The care plan did not specify the resident required the physical assistance of two persons for bed mobility as per the Admission MDS assessment.</p> <p>The care plan initiated on _____ noted Resident #999 was at risk for _____ related to decreased cognition and decreased mobility. The goal was, "The risk for _____ will be minimized through the next review." The interventions included to be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed and evaluate the resident's environment to identify factors known to increase risk of _____.</p>	F 600	<p>(s).</p> <p>_____, and ongoing all staff re-educated by the DCS/designee regarding the components of this regulation with the emphasis on the following: "_____, neglect and _____ - ensure that while providing care Policies and procedures are being adhered to and no intentional neglect is being performed while providing care.</p> <p>"On _____ - ongoing the implementation of enhanced task added to the Kardex for a quicker review for staff to see the residents need for assistance such as: dependent, extensive, limited, supervision or independent care needed</p> <p>4.How the corrective action(s) will be monitored to ensure the practice will not recur, ie what Quality Assurance Program will be put in place: -The DCS/ designee will conduct audits on 10 residents weekly x 4, then bi-weekly X4, then monthly x 1 and PRN on the following:</p> <p>"Ensure the Kardex has the enhanced task present "Ensure task for new admissions and residents with a change in ADLs are promptly updated to reflect current condition. "Ensure policy and procedures are being followed</p>	

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F 600	<p>Continued From page 4</p> <p>On at 8:40 a.m., in an interview Unit Manager Registered Nurse (RN) Staff B said, "I was in Rose Garden secured unit when [Resident #999] . I applied ice and printed the paperwork to send him to the hospital. He went to the hospital and did not return. He was a two person assist with care. [CNA Staff A] said she did not have another person with her."</p> <p>On at 8:48 a.m., in an interview RN Staff C said she works the 11:00 p.m. to 7:00 a.m., shift on the North Unit. She said, "We regularly keep the Kardex up to date. The Unit managers and the nurses can do it. If the CNA notices any changes they tell us. If the resident has had any changes we update the Kardex."</p> <p>On at 8:52 a.m., in an interview North Unit Manager Licensed Practical Nurse Staff C said the CNAs and nurses get resident information from the Kardex and report from the nurse. Unit Managers and MDS nurses mostly update the Kardex. We received recent education to ensure the Kardex is updated and reviewed at the beginning of every shift.</p> <p>On at 11:05 a.m., in a telephone interview CNA Staff A said, "I was working the 3:00 p.m., to 11:00 p.m., shift on . I had worked with Resident #999 before. I went to do my last rounds to see if he needed to be changed. I had him positioned in bed to the left side facing the door. I realized he did not have a fitted sheet on the bed, and I went to get one. Before I turned him on his , flat on his in bed. He had an air mattress. I did the upper part of the sheet first. I had all the soiled linen and brief rolled up and against him. I went to place the bottom of the fitted sheet on the bed and he began to roll out of the bed. I tried to stop him but I did not make it.</p>	F 600	<p>"Ensure stakeholder (s) are not providing neglectful care</p> <p>The findings of these quality monitoring to be reported to the Quality Assurance Program Improvement Committee monthly. Quality monitoring schedule to be modified based on the findings with quarterly monitoring by the Regional Director of Clinical Services/ designee.</p>	

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F 600	<p>Continued From page 5</p> <p>He out of bed. I saw him and I did not see any , so I ran to get the nurse. When we got to the room, there was everywhere. He had a to his right arm and it was . What I did wrong was I did not roll him toward me like I should have. I always did him by myself and no one ever told me he was a two person assist. I never knew about the care Kardex. They told me about the Kardex after the fact. I know you need to have two people with a , but he was already in bed, I just wanted to change him. They gave education after the fact. If I had known before, I would have had help, but no one ever told me anything about him. It all happened so fast." Review of the Certified Nursing Aide, Competency Checkoff List revealed Staff A completed "Review Kardex" on</p> <p>On at 11:45 a.m., in an interview the Administrator said Resident #999 was always a two person assist. From the re-enactment with CNA Staff A, using a pillow to demonstrate, she stood at the bed and he was in the center of the bed, she rolled him away from her and he was at the edge of the bed. I educated her the resident needs to be closer to you so when you turn him he is not so close to the edge, do not center the resident.</p> <p>On at 11:55 a.m., in an interview Occupational () Staff G said Resident #999 was on caseload when he was first admitted and he required two persons assist with all his care needs. He said Hospice got involved and had their own , seeing the resident but the resident was always two persons assist with his care.</p>	F 600			

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F 689 F 689 SS=G	<p>Continued From page 6</p> <p>Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)</p> <p>§483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and</p> <p>§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to ensure the safety interventions were documented in the care plan and failed to ensure staff used safe repositioning technique to prevent avoidable and related serious injury for 1 (Resident #999) of 4 dependent residents reviewed.</p> <p>The findings included:</p> <p>Review of the clinical record revealed Resident #999 was a . . . male with an admission date of Diagnoses included right side (. . . . on one side of the body) and (. . . . of one side of the body) related to , and a history of</p> <p>Review of the New Admission Evaluation form dated revealed Resident #999 required the physical assistance of two persons for bed mobility.</p> <p>The care plan initiated on identified Resident #999 was at risk for related to decreased cognition and decreased mobility. The resident had activity of daily living self-care performance due to"</p>	F 689 F 689	<p>1. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>-On upon immediate discovery the resident # 999 received first aid and transferred to a higher level of care for evaluation and treatment as indicated by Staff member B. -Resident #999 no longer resided at the facility.</p> <p>2. How will you identify other residents having potential to be affected by the same deficient practice and what corrective actions will be taken:</p> <p>-Quality review performed on by DCS/designee of the residents in which Staff member A provided care</p>		

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F 689	<p>Continued From page 7</p> <p>/decreased cognition, and</p> <p>The interventions noted the resident had an air mattress to his bed and was, "dependent with rolling left to right". The care plan did not specify the resident required the physical assistance of two persons for bed mobility as per the Admission evaluation.</p> <p>The Significant Change in Status Minimum Data Set (MDS) assessment (standardized tool that measures health status in nursing home residents) with an assessment reference date of documented Resident #999's skills for daily decision making were severely understood. Resident #999 was rarely/never on one side of the upper extremities and both sides of the lower extremities. Resident #999 was dependent on staff for activities of daily living, including bed mobility, rolling left and right (Helper does all of the effort, Resident does none of the effort to complete the activity).</p> <p>Review of the progress notes revealed on Resident #999 had a resulting in a hematoma (collection of outside of the) to the right cheek and a to the right</p> <p>Resident #999 was transferred to the local hospital for evaluation.</p> <p>Review of the hospital documentation for revealed Resident #999 had a (Computerized) of the with findings of acute intra-axial () within the left frontal (of the) measuring 2.0 by 1.7 by 2.4 cm (centimeters).</p> <p>Review of the investigation initiated on revealed Certified Nursing Assistant (CNA) Staff A was changing Resident #999. She turned the</p>	F 689	<p>to ensure no other resident sustained a or injuries related to her failure to follow the Kardex and policy and procedures for bed mobility (assist of 2- dependent care). No deficient practice noted.</p> <p>-Quality review performed on by DCS/designee of all residents that reside in the facility to ensure no injuries were sustained during care and stakeholders were utilizing the Kardex to provide proper care. No deficient practice noted.</p> <p>3.What measures will be put in place or what systemic changes you will make to ensure that the practice does not recur:</p> <p>-On and ongoing nursing staff re- educated on the components of this regulation with emphasis on:</p> <ul style="list-style-type: none"> -Stakeholders aware to review Kardex prior to providing care -Stakeholders are to ensure they have the correct number of Staff members to provide care. <p>Stakeholders are to ensure proper bed mobility (always turn a resident toward you not away).</p> <p>"Ensure stakeholders are efficient and familiar with Policy, procedures and processes prior to caring for</p>	

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F 689	Continued From page 8 resident to the left side to remove the brief and change the fitted sheet on the bed. As she was placing the fitted sheet on the bed she went to tuck it under and saw the resident move more off the bed. She placed her on his side to hold him, he went off falling off the bed because his was too heavy on one side. Once the resident "hit the floor" CNA Staff A went into the hallway to get help from a CNA or a nurse. A nurse on duty documented CNA Staff A call to her and said Resident #999 . Upon arrival to the resident's room, she observed the resident on the floor on his right side. Resident #999 had a hematoma to the right side of the . Unit Manager Registered Nurse (RN) Staff B obtained a statement from CNA Staff A who said she always cared for Resident #999 and has not had a problem with caring for him. She was changing the resident and the sheets. She rolled the resident over and saw him begin to move and when she went to hold/grab him, he . CNA Staff A said no one ever told her she needed two people to care for the resident. She had taken care of him several times and had no problem. CNA Staff A said it just happened so fast. The facility's investigation noted on CNA Staff A demonstrated how she had Resident #999 centered and as she turned him, he was more toward the other side, away from her which resulted in him falling as he moved. The facility's investigation noted CNA Staff A was given one to one education on proper positioning and following the Kardex (System of communication and organization used in nursing that helps long term care facilities document resident care summaries) for transfer status. Review of the Kardex failed to reveal documentation Resident #999 required two	F 689	residents through continual education, competencies and monitoring. 4.How the corrective action (s) will be monitored to ensure the practice will not recur, ie what Quality Assurance program will be put in place: The DCS/designee will conduct audits on 10 residents weekly x 4, then bi-wkly x 4, then monthly x 1 and PRN on the following: -Ensure resident is free from injury while receiving care -Ensure Kardex is followed and appropriate care provided The findings of these quality monitoring to be reported to the Quality Assurance Program Improvement Committee monthly. Quality monitoring schedule to be modified based on findings with quarterly monitoring by the Regional Director of Clinical Services/ designee.	

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F 689	<p>Continued From page 9</p> <p>persons assistance for bed mobility.</p> <p>Review of the "Education/Training" provided to CNA Staff A on noted, "When providing care for patients in the bed and turning patient away from you ensure patient is positioned on the side of the bed closest to you to minimize risk of from the bed and maintain safety. Start of shift, review Kardex for each patient to follow plan of care and transfer status."</p> <p>On at 8:40 a.m., in an interview Unit Manager Registered Nurse (RN) Staff B said, "I was in Rose Garden secured unit when [Resident #999] . I applied ice and printed the paperwork to send him to the hospital. He went to the hospital and did not return. He was a two person assist with care. [CNA Staff A] said she did not have another person with her."</p> <p>On at 8:48 a.m., in an interview RN Staff C said she works the 11:00 p.m. to 7:00 a.m., shift on the North Unit. She said, "We regularly keep the Kardex up to date. The Unit managers and the nurses can do it. If the CNA notices any changes they tell us. If the resident has had any changes we update the Kardex."</p> <p>On at 11:05 a.m., in a telephone interview CNA Staff A said, "I was working the 3:00 p.m., to 11:00 p.m., shift on . I had worked with Resident #999 before. I went to do my last rounds to see if he needed to be changed. I had him positioned in bed to the left side facing the door. I realized he did not have a fitted sheet on the bed, and I went to get one. Before I turned him on his , flat on his in bed. He had an air mattress. I did the upper part of the sheet first. I had all the soiled linen and brief rolled up and against him. I went to place the bottom of the</p>	F 689		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/05/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105462	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/07/2025
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F 689	<p>Continued From page 10</p> <p>flitted sheet on the bed and he began to roll out of the bed. I tried to stop him but I did not make it. He out of bed. I saw him and I did not see any , so I ran to get the nurse. When we got to the room, there was everywhere. He had a to his right arm and it was . What I did wrong was I did not roll him toward me like I should have. I always did him by myself and no one ever told me he was a two person assist. I never knew about the care Kardex. They told me about the Kardex after the fact. I know you need to have two people with a , but he was already in bed, I just wanted to change him. They gave education after the fact. If I had known before, I would have had help, but no one ever told me anything about him. It all happened so fast."</p> <p>On at 11:45 a.m., in an interview the Administrator said Resident #999 was always a two person assist. From the re-enactment with CNA Staff A, using a pillow to demonstrate, she stood at the bed and he was in the center of the bed, she rolled him away from her and he was at the edge of the bed. I educated her the resident needs to be closer to you so when you turn him he is not so close to the edge, do not center the resident. The Administrator added she thought the placement of the resident in the center of the bed was the root cause of the but she had 15 days to determine that.</p>	F 689			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 82601	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/07/2025
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NAME OF PROVIDER OR SUPPLIER VIVO HEALTHCARE CLEWISTON	STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH GLORIA ST CLEWISTON, FL 33440
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N 000	<p>INITIAL COMMENTS</p> <p>An unannounced complaint survey for #2025004503 was conducted on at Clewiston Nursing and Rehabilitation, a skilled nursing facility in Clewiston Florida.</p> <p>Complaint #2025004503 was substantiated with citation at N201 and N204.</p> <p>The following is the description of the deficiencies.</p>	N 000		
N 201 SS=G	<p>400.022(1)(f), FS Right to Adequate and Appropriate Health Care</p> <p>(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.</p> <p>This Statute or Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure the safety interventions were documented in the care plan and failed to ensure staff used safe repositioning technique to prevent avoidable and related serious injury for 1 (Resident #999) of 4 dependent residents reviewed.</p> <p>The findings included:</p> <p>Review of the clinical record revealed Resident #999 was a male with an admission date of Diagnoses included right side (on one side of the body)</p>	N 201	<p>1.What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>-On upon immediate discovery the resident # 999 received first aid and transferred to a higher level of care for evaluation and treatment as indicated by Staff member B.</p> <p>-Resident #999 no longer resided at the</p>	

AHCA Form 3020-0001 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X8) DATE
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Electronically Signed /25

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N 201	Continued From page 1 and _____ (_____ of one side of the body) related to _____, and a history of _____ Review of the New Admission Evaluation form dated _____ revealed Resident #999 required the physical assistance of two persons for bed mobility. The care plan initiated on _____ identified Resident #999 was at risk for _____ related to decreased cognition and decreased mobility. The resident had activity of daily living self-care performance _____ due to, "_____/decreased cognition, _____, and _____" The interventions noted the resident had an air mattress to his bed and was, "dependent with rolling left to right". The care plan did not specify the resident required the physical assistance of two persons for bed mobility as per the Admission evaluation. The Significant Change in Status Minimum Data Set (MDS) assessment (standardized tool that measures health status in nursing home residents) with an assessment reference date of _____ documented Resident #999's _____ skills for daily decision making were severely _____ . Resident #999 was rarely/never understood. The resident's range of motion was _____ on one side of the upper extremities and both sides of the lower extremities. Resident #999 was dependent on staff for activities of daily living, including bed mobility, rolling left and right (Helper does all of the effort, Resident does none of the effort to complete the activity). Review of the progress notes revealed on Resident #999 had a _____ resulting in a hematoma (collection of _____ outside of the _____) to the right cheek and a _____ to the right _____ . Resident #999 was transferred to the local _____	N 201	facility. 2.How will you identify other residents having potential to be affected by the same deficient practice and what corrective actions will be taken: -Quality review performed on _____ by DCS/designee of the residents in which Staff member A provided care to ensure no other resident sustained a _____ or injuries related to her failure to follow the Kardex and policy and procedures for bed mobility (assist of 2- dependent care). No deficient practice noted. -Quality review performed on _____ by DCS/designee of all residents that reside in the facility to ensure no injuries were sustained during care and stakeholders were utilizing the Kardex to provide proper care. No deficient practice noted. 3.What measures will be put in place or what systemic changes you will make to ensure that the practice does not recur: -On _____ and ongoing nursing staff re-educated on the components of this regulation with emphasis on: -Stakeholders aware to review Kardex prior to providing care	

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N 201	<p>Continued From page 2</p> <p>hospital for evaluation.</p> <p>Review of the hospital documentation for revealed Resident #999 had a (Computerized _____) of the _____ with findings of acute intra-axial _____ (of the _____) within the left frontal _____ measuring 2.0 by 1.7 by 2.4 cm (centimeters).</p> <p>Review of the _____ investigation initiated on revealed Certified Nursing Assistant (CNA) Staff A was changing Resident #999. She turned the resident to the left side to remove the brief and change the fitted sheet on the bed. As she was placing the fitted sheet on the bed she went to tuck it under and saw the resident move more off the bed. She placed her _____ on his side to hold him, he went off falling off the bed because his _____ was too heavy on one side. Once the resident "hit the floor" CNA Staff A went into the hallway to get help from a CNA or a nurse.</p> <p>A nurse on duty documented CNA Staff A call to her and said Resident #999 _____. Upon arrival to the resident's room, she observed the resident on the floor on his right side. Resident #999 had a hematoma to the right side of the _____.</p> <p>Unit Manager Registered Nurse (RN) Staff B obtained a statement from CNA Staff A who said she always cared for Resident #999 and has not had a problem with caring for him. She was changing the resident and the sheets. She rolled the resident over and saw him begin to move and when she went to hold/grab him, he _____. CNA Staff A said no one ever told her she needed two people to care for the resident. She had taken care of him several times and had no problem. CNA Staff A said it just happened so fast.</p> <p>The facility's investigation noted on _____ CNA Staff A demonstrated how she had Resident #999 centered and as she turned him, he was more</p>	N 201	<p>-Stakeholders are to ensure they have the correct number of Staff members to provide care. Stakeholders are to ensure proper bed mobility (always turn a resident toward you not away).</p> <p>Ensure stakeholders are efficient and familiar with Policy, procedures and processes prior to caring for residents through continual education, competencies and monitoring.</p> <p>4.How the corrective action (s) will be monitored to ensure the practice will not recur, ie what Quality Assurance program will be put in place: The DCS/designee will conduct audits on 10 residents weekly x 4, then bi-wkly x 4, then monthly x 1 and PRN on the following:</p> <p>-Ensure resident is free from injury while receiving care -Ensure Kardex is followed and appropriate care provided</p> <p>The findings of these quality monitoring to be reported to the Quality Assurance Program Improvement Committee monthly. Quality monitoring schedule to be modified based on findings with quarterly monitoring by the Regional Director of Clinical Services/ designee.</p>	

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N 201	<p>Continued From page 3</p> <p>toward the other side, away from her which resulted in him falling as he moved. The facility's investigation noted CNA Staff A was given one to one education on proper positioning and following the Kardex (System of communication and organization used in nursing that helps long term care facilities document resident care summaries) for transfer status. Review of the Kardex failed to reveal documentation Resident #999 required two persons assistance for bed mobility.</p> <p>Review of the "Education/Training" provided to CNA Staff A on noted, "When providing care for patients in the bed and turning patient away from you ensure patient is positioned on the side of the bed closest to you to minimize risk of from the bed and maintain safety. Start of shift, review Kardex for each patient to follow plan of care and transfer status."</p> <p>On at 8:40 a.m., in an interview Unit Manager Registered Nurse (RN) Staff B said, "I was in Rose Garden secured unit when [Resident #999] . I applied ice and printed the paperwork to send him to the hospital. He went to the hospital and did not return. He was a two person assist with care. [CNA Staff A] said she did not have another person with her."</p> <p>On at 8:48 a.m., in an interview RN Staff C said she works the 11:00 p.m. to 7:00 a.m., shift on the North Unit. She said, "We regularly keep the Kardex up to date. The Unit managers and the nurses can do it. If the CNA notices any changes they tell us. If the resident has had any changes we update the Kardex."</p> <p>On at 11:05 a.m., in a telephone interview CNA Staff A said, "I was working the 3:00 p.m., to 11:00 p.m., shift on . I had worked with</p>	N 201		

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N 201	Continued From page 4 Resident #999 before. I went to do my last rounds to see if he needed to be changed. I had him positioned in bed to the left side facing the door. I realized he did not have a fitted sheet on the bed, and I went to get one. Before I turned him on his _____, flat on his _____ in bed. He had an air mattress. I did the upper part of the sheet first. I had all the soiled linen and brief rolled up and against him. I went to place the bottom of the fitted sheet on the bed and he began to roll out of the bed. I tried to stop him but I did not make it. He _____ out of bed. I saw him and I did not see any _____, so I ran to get the nurse. When we got to the room, there was _____ everywhere. He had a _____ to his right arm and it was _____. What I did wrong was I did not roll him toward me like I should have. I always did him by myself and no one ever told me he was a two person assist. I never knew about the care Kardex. They told me about the Kardex after the fact. I know you need to have two people with a _____, but he was already in bed, I just wanted to change him. They gave education after the fact. If I had known before, I would have had help, but no one ever told me anything about him. It all happened so fast." On _____ at 11:45 a.m., in an interview the Administrator said Resident #999 was always a two person assist. From the re-enactment with CNA Staff A, using a pillow to demonstrate, she stood at the bed and he was in the center of the bed, she rolled him away from her and he was at the edge of the bed. I educated her the resident needs to be closer to you so when you turn him he is not so close to the edge, do not center the resident. The Administrator added she thought the placement of the resident in the center of the bed was the root cause of the _____ but she had 15 days to determine that.	N 201		

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N 201	Continued From page 5 Class II	N 201		
N 204 SS=G	<p>400.022(1)(o), FS Right to be Free from , , etc</p> <p>400.022, F. S. (1)(o) All licensees of nursing home facilities shall adopt and make public a statement of the rights and responsibilities of the residents of such facilities and shall treat such residents in accordance with the provisions of that statement. The statement shall assure each resident the following:</p> <p>(o) The right to be free from mental and , , neglect, , corporal punishment, extended involuntary , and , corporal punishment, extended involuntary , and physical and chemical , except those authorized in writing by a physician for a specified and limited period of time or as are necessitated by an emergency. In case of an emergency, may be applied only by a qualified licensed nurse who shall set forth in writing the circumstances requiring the use of , and, in the case of use of a chemical , a physician shall be consulted immediately thereafter. may not be used in lieu of staff supervision or merely for staff convenience, for punishment, or for reasons other than resident protection or safety.</p> <p>This Statute or Rule is not met as evidenced by: Based on record review and staff interviews the facility failed to protect the residents' right to be free from neglect for 1 (Resident #999) of 4</p>	N 204	1.What corrective action(s) will be accomplished for those residents found to have been	

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N 204	<p>Continued From page 6</p> <p>sampled residents by failing to follow safety precautions while providing care to prevent avoidable and related major injury.</p> <p>The findings included:</p> <p>Review of the facility's neglect investigations revealed on at approximately 6:40 p.m., Certified Nursing Assistant (CNA) Staff A was providing care to Resident #999. The CNA turned the resident on his left side to remove his brief. The resident "moved more off the bed as she placed her on his side to hold him he went falling." The incident investigation noted Resident #999 sustained "a red discoloration to the right side of his and a on his right ". Resident #999 was transferred to a local hospital and diagnosed with an acute intra-axial () within the left frontal (front of the) measuring 2.0 by 1.07 by 2.4 centimeters.</p> <p>The investigation noted CNA staff A turned Resident #999 on his left side to remove his brief and bed sheet. As she was placing the fitted sheet on the bed she saw the resident "moving more off the bed" so she placed her on his side to hold him. The resident off the bed because his "was too heavy on one side." Once the resident "the floor" she went out into the hallway to get help. The investigation noted the nurse arrived in the room, observed Resident #999 on his right side with a hematoma (collection of outside the) on the right side of the .</p> <p>As part of the investigation, on CNA Staff A demonstrated she had the resident centered and as she turned him, he was more toward the other side, away from her which resulted in the resident's falling as he moved.</p>	N 204	<p>affected by the deficient practice:</p> <p>-On , upon immediate discovery resident #999 was assessed, received first aid, and transferred to a higher level of care for further evaluation and treatment as indicated.</p> <p>-On , investigation immediately initiated, Staff member A suspended pending the outcome of the investigation.</p> <p>-On , staff member A along with the Executive Director performed a reenactment of the incident that resulted in a mechanical , it revealed the stakeholder failed to follow policy and performed toileting hygiene, which includes bed mobility independently.</p> <p>2.How you will identify other residents having potential to be affected by the same deficient practice and what corrective actions will be taken: -A quality review was performed on , by the Executive Director and DCS of all residents that reside in the facility in which staff member A provided care to ensure no other residents</p>	

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N 204	<p>Continued From page 7</p> <p>The facility verified the allegation of neglect and noted CNA Staff A would be terminated for failure to follow the facility's policy and procedures related to reviewing residents Kardex (System of communication and organization used in nursing that helps long term care facilities document resident care summaries).</p> <p>Review of the Kardex revealed to turn and reposition Resident #999 every two hours and as needed. The Kardex did not specify that the resident required the physical assistance of two persons for bed mobility, including turning and repositioning as per the Nursing Admission evaluation.</p> <p>Review of the staff education dated noted "Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, , , mental anguish or emotional distress."</p> <p>Review of the facility new employee education and in-service training revealed, " At the start of the shift, read the Kardex for updated changes such as interventions in place for bed mobility, transfer status, , , behaviors."</p> <p>Review of the clinical record revealed Resident #999 was a male with an admission date of . Diagnoses included right side (on one side of the body) and (of one side of the body) related to , , and a history of .</p> <p>The Admission Minimum Data Set (MDS) assessment (standardized tool that measures health status in nursing home residents) with an assessment reference date of</p>	N 204	<p>sustained a due to improper bed mobility and free from or neglect. No discrepancies noted.</p> <p>-A quality review was performed on , by the Director/ DCS/UM of all residents that reside in the facility of their Kardex and Careplan ensuring that bed mobility was present and accurate. No noted discrepancies. The information was present, accurate and accessible to all nursing staff.</p> <p>3.What measures will be put in place or what systemic changes you will make to ensure that the practice does not recur:</p> <p>-On , and ongoing the nursing staff re-educated by the DCS/ Designee regarding the components of this regulation with the emphasis on the following: "Kardex use- ensuring the Kardex is reviewed and followed prior to providing care for the resident. " Bed mobility- ensure proper bed mobility is used to include but not limited to the correct number of people to complete the task and always roll a resident towards you never away. Ensure the proper number of people are present to perform the task (s).</p>	

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N 204	<p>Continued From page 8</p> <p>documented Resident #999 was dependent for bathing, toileting, personal hygiene and bed mobility (Helper does all of the effort, Resident does none of the effort to complete the activity). The MDS noted Resident #999's skills for daily decision making were severely . Resident #999 was rarely/never understood. Review of the New Admission Re-Admission Evaluation form dated revealed Resident #999 required the physical assistance of two persons for bed mobility. Resident #999 scored "18" on the risk evaluation upon admission indicating the resident was at high risk for . The care plan initiated on identified Resident #999 had activity of daily living self-care performance due to, " /decreased cognition, , and . The interventions noted the resident had an air mattress to his bed and was, "dependent with rolling left to right". The care plan did not specify the resident required the physical assistance of two persons for bed mobility as per the Admission MDS assessment. The care plan initiated on noted Resident #999 was at risk for related to decreased cognition and decreased mobility. The goal was, "The risk for will be minimized through the next review." The interventions included to be sure the resident's call light is within reach and encourage the resident to use if for assistance as needed and evaluate the resident's environment to identify factors known to increase risk of .</p> <p>On at 8:40 a.m., in an interview Unit Manager Registered Nurse (RN) Staff B said, "I was in Rose Garden secured unit when [Resident #999] . I applied ice and printed the paperwork</p>	N 204	<p>and ongoing all staff re-educated by the DCS/designee regarding the components of this regulation with the emphasis on the following: " , neglect and - ensure that while providing care Policies and procedures are being adhered to and no intentional neglect is being performed while providing care. "On - ongoing the implementation of enhanced task added to the Kardex for a quicker review for staff to see the residents need for assistance such as: dependent, extensive, limited, supervision or independent care needed</p> <p>4. How the corrective action(s) will be monitored to ensure the practice will not recur, ie what Quality Assurance Program will be put in place: -The DCS/ designee will conduct audits on 10 residents weekly x 4, then bi- weekly X4, then monthly x 1 and PRN on the following: "Ensure the Kardex has the enhanced task present "Ensure task for new admissions and residents with a change in ADLs are promptly updated to reflect current condition. "Ensure policy and procedures are being followed "Ensure stakeholder (s) are not providing neglectful care The findings of these quality monitoring to</p>	

Agency for Health Care Administration

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NAME OF PROVIDER OR SUPPLIER VIVO HEALTHCARE CLEWISTON		STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH GLORIA ST CLEWISTON, FL 33440		
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N 204	<p>Continued From page 9</p> <p>to send him to the hospital. He went to the hospital and did not return. He was a two person assist with care. [CNA Staff A] said she did not have another person with her."</p> <p>On at 8:48 a.m., in an interview RN Staff C said she works the 11:00 p.m. to 7:00 a.m., shift on the North Unit. She said, "We regularly keep the Kardex up to date. The Unit managers and the nurses can do it. If the CNA notices any changes they tell us. If the resident has had any changes we update the Kardex."</p> <p>On at 8:52 a.m., in an interview North Unit Manager Licensed Practical Nurse Staff C said the CNAs and nurses get resident information from the Kardex and report from the nurse. Unit Managers and MDS nurses mostly update the Kardex. We received recent education to ensure the Kardex is updated and reviewed at the beginning of every shift.</p> <p>On at 11:05 a.m., in a telephone interview CNA Staff A said, "I was working the 3:00 p.m., to 11:00 p.m., shift on . I had worked with Resident #999 before. I went to do my last rounds to see if he needed to be changed. I had him positioned in bed to the left side facing the door. I realized he did not have a fitted sheet on the bed, and I went to get one. Before I turned him on his , flat on his in bed. He had an air mattress. I did the upper part of the sheet first. I had all the soiled linen and brief rolled up and against him. I went to place the bottom of the fitted sheet on the bed and he began to roll out of the bed. I tried to stop him but I did not make it. He out of bed. I saw him and I did not see any , so I ran to get the nurse. When we got to the room, there was everywhere. He had a to his right arm and it was . What I did wrong was I did not roll him</p>	N 204	<p>be reported to the Quality Assurance Program Improvement Committee monthly. Quality monitoring schedule to be modified based on the findings with quarterly monitoring by the Regional Director of Clinical Services/ designee.</p>	

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N 204	<p>Continued From page 10</p> <p>toward me like I should have. I always did him by myself and no one ever told me he was a two person assist. I never knew about the care Kardex. They told me about the Kardex after the fact. I know you need to have two people with a , but he was already in bed, I just wanted to change him. They gave education after the fact. If I had known before, I would have had help, but no one ever told me anything about him. It all happened so fast." Review of the Certified Nursing Aide, Competency Checkoff List revealed Staff A completed "Review Kardex" on</p> <p>On at 11:45 a.m., in an interview the Administrator said Resident #999 was always a two person assist. From the re-enactment with CNA Staff A, using a pillow to demonstrate, she stood at the bed and he was in the center of the bed, she rolled him away from her and he was at the edge of the bed. I educated her the resident needs to be closer to you so when you turn him he is not so close to the edge, do not center the resident.</p> <p>On at 11:55 a.m., in an interview Occupational () Staff G said Resident #999 was on caseload when he was first admitted and he required two persons assist with all his care needs. He said Hospice got involved and had their own , seeing the resident but the resident was always two persons assist with his care.</p> <p>Class II</p>	N 204			