

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 93102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/12/2025
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NAME OF PROVIDER OR SUPPLIER VERO BEACH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1310 37TH ST VERO BEACH, FL 32960
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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N 000	<p>INITIAL COMMENTS</p> <p>An unannounced Licensure complaint survey, complaint numbers 2025000831, 2025001329 and 2025001493, was conducted on through at Vero Beach Care Center. The facility had deficiencies at the time of the survey.</p> <p>Complaint number 2025000831 was substantiated with deficiencies and cited at N201.</p>	N 000		
N 201 SS=D	<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 observation, record review and interview, the facility failed to provide necessary care and services to prevent, identify and properly assess , for 2 of 2 sampled residents reviewed for (Resident #1 and #3), as evidenced by the facility failed to implement preventative measures to minimize the development of , for Resident #1. The staff were aware the resident preferred to stay on his due to the in use, there was no documentation of the resident refusal to offload his heels, and the treatment to mitigate , with skin prep, was initiated after the first developed on ; and for 1 of 2 sampled residents</p>	N 201	<p>N201: Right to Adequate and Appropriate Healthcare.</p> <p>1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident #1, no longer resides in the facility, discharged on .</p> <p>Resident #3, On resident #3 was immediately assessed by a licensed nurse for any adverse effects related to the alleged deficient practice, none were noted. The Attending Physician and care ARNP were immediately</p>	

AHCA Form 3020-0001 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Electronically Signed

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N 201	<p>Continued From page 1</p> <p>reviewed for (Resident #3), as evidenced by the facility failed to identify the or subsequent open to the resident's right , prior to surveyor intervention; the nurse failed to properly assess the , documenting erroneous measurements and the staff nurse failed to capture the . during skin check assessment completed on , the day before the surveyor observation.</p> <p>The findings included:</p> <p>Review of the policy, titled, " Care and Treatment", revised , documented, in part:</p> <p>"Standard: The purpose of this procedure is to provide guidelines for the care of to promote healing.</p> <p>Guideline: Only staff trained to complete physician orders will complete care and treatments as prescribed.</p> <p>Procedure: Preparation 1. Verify that there is a physician's order for this procedure... 4. Assess residents , level as needed.</p> <p>Equipment and Supplies: The following equipment and supplies will be necessary when performing this procedure... 12. Assess residents tolerance of care throughout the procedure. 16. Reposition the bed covers. Make the resident comfortable. Use supportive devices as instructed.</p> <p>Documentation: The following information should be recorded in the resident's medical record: I. The type of care given... 4. Any change in the resident's condition. 5. Any problems or complaints made by the</p>	N 201	<p>notified, orders for treatment received and treatment initiated on . An order effective . was created to provide off-loading; treatment to Resident #3.</p> <p>2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken;</p> <p>Licensed Nursing staff will conduct weekly skin audits to monitor the residents for change in skin condition.</p> <p>3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not reoccur.</p> <p>On , the Assisted Director of Nursing/ designee, initiated education on the components of the Failure to provide necessary care and services to prevent and promote healing of , with emphasis on providing treatment to ensure the healing of the ,</p> <p>4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place: The Assistant Director of Nursing/ designee will conduct random audits of 5 resident with to ensure that their treatment and services have been provided according to their Physician</p>	

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N 201	Continued From page 2 resident related to the procedure. Reporting: 2. Report other information in accordance with facility policy and professional standards practice.* 1. Observation of care conducted on at 10:20 AM revealed the Care Nurse (WCN) prepared supplies for Resident #3 and explained the floor nurse had previously medicated the resident for . . . The WCN prepared solution, . . . skin prep, and border gauze, the unit manager was present during the observation. Resident #3 was severely . . . It was noted the resident had a pillow between the . . . and a green . . . was in place to the left . . . The nurse performed hygiene, opened all the supplies, forcefully removed the pillow from between the resident's . . . The resident yelled and the WCN explained he had to remove it to do his . . . The WCN then removed the green . . . by lifting the resident's . . . and the resident yelled again. The WCN proceeded to remove the dirty . . . cleansed the area with the . . . solution, and again the resident yelled when the solution was applied. The WCN continued by applying skin prep around the . . . applied the . . . and dry border gauze and reapplied the . . . Interview with the WCN conducted upon completion of the care observation, confirmed the staff failed to perform hygiene after removing the dirty . . . and prior to cleansing the . . . and applying the treatment. The WCN reiterated the resident was medicated for . . . prior to the treatment. The WCN did not	N 201	Orders, 2x a week for 4 weeks, then 1x week for 4 weeks and then monthly for 1 month to ensure compliance. The findings of these quality monitoring to be reported to the Quality Assurance/Performance Improvement Committee monthly until substantial compliance has been met.	

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N 201	<p>Continued From page 3</p> <p>acknowledge the resident's tolerance to the treatment.</p> <p>Clinical record review conducted on revealed Resident #3 has diagnoses that included and</p> <p>Review of the Minimum Data Set (MDS), quarterly assessment with reference date of documented the resident was assessed as severely for skills of daily decision making, and has a present on reentry.</p> <p>Review of the care plans, titled "The resident is at risk for skin related to and decreased mobility, initiated on and revised on revealed the plan documented interventions including "patient to have cushion/ positioning device(black) on to be removed for when in wheelchair, for skin check, hygiene, shower and tolerance. To be on in AM/Off in PM. Can be removed for skin check, range of motion and hygiene as ordered and skin checks weekly and as indicated. Report any signs of to physician and team as indicated."</p> <p>Review of the Physician's order dated documented " care left lateral fifth: Cleanse with cleanser - dry, apply skin prep to peri apply 0.1%, cover with border gauze, every Tuesday, Thursday and Saturday. PLACE GREEN</p> <p>The observation determined the WCN failed to follow policies and procedures during the</p>	N 201		

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N 201	<p>Continued From page 4</p> <p>treatment administration to promote healing and minimize risk of</p> <p>2. Observation of care conducted on at 10:20 AM revealed the Care Nurse (WCN) performed care for Resident #3's left</p> <p>At the end of the treatment, the surveyor asked the reason why the was only applied to the left as the resident was severely on both . The WCN responded that the resident prefers to lay on the left side and that is where the is located, so an is not necessary to the right</p> <p>The WCN was asked if the resident had any to the right or and replied 'no'. At this time, the resident spoke up and said, yes he had to the right . The WCN then proceeded to inspect the right . An open was noted to the right . . . below the big , that looked like a that had opened up, with visible depth and yellow . . . about the size of a dime. The WCN stated he was going to contact the physician for treatment orders and that the provider would evaluate the resident tomorrow (Thursday).</p> <p>Interview with the WCN, conducted upon completion of the care observation, on at approximately 10:30 AM, revealed the nurse had no knowledge of a previous or to the right and stated that he has provided the care to the left but has not inspected the right . He stated the care provider rounds weekly and inspects the resident's skin, so the was not present last Thursday.</p>	N 201		

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N 201	<p>Continued From page 5</p> <p>An interview was conducted with Staff A, Certified Nursing Assistant (CNA), assigned to care for Resident #3, on _____ at 10:37 AM. Staff A stated she has not seen the resident as of yet today, she has a heavy assignment, was attending to other residents, and did not have the resident the day before. Staff A denied knowledge of any _____ or _____ to the right _____.</p> <p>An interview with Staff B, Registered Nurse (RN), conducted on _____ at approximately 10:46 AM, revealed this is her regular hallway assignment, and she is not aware of a _____ or _____ to the resident's right _____.</p> <p>Clinical record review conducted on _____ revealed Resident #3 has diagnoses that included _____ and _____.</p> <p>Review of the Minimum Data Set (MDS), quarterly assessment with reference date of _____, documented the resident was assessed as severely _____ for skills of daily decision making, and has a _____ present on reentry.</p> <p>Review of the care plan, titled, "The resident is at risk for skin _____ related to _____ /decreased mobility, _____, left _____ multiple sites (left & right _____), _____, left _____ right dorsal _____ and right heel", was initiated on _____ and revised on _____.</p> <p>The plan documented interventions including _____ patient to have _____ cushion/ _____ positioning device (black) on to be removed when in wheelchair, for skin check, hygiene, shower and tolerance. To be on in AM/Off in PM. Can be removed for skin check, range of motion and _____</p>	N 201		
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N 201	<p>Continued From page 6</p> <p>hygiene as ordered and skin checks weekly and as indicated, report any signs of to physician and . . . team as indicated."</p> <p>Review of the weekly skin assessments, the progress notes and the . . . care notes failed to document the presence of a . . . to the right . . .</p> <p>Review of the Progress notes dated . . . documented the WCN measured the right . . . noting 1.5 centimeter (cm) in length, 2.0 cm in width, 0 cm in depth. The surveyor's observation validates the newly identified had depth, it was not a superficial . . . , and the noted assessment was not accurate.</p> <p>An interview with the Director of Nursing (DON) conducted on . . . at approximately 12:20 PM, revealed that last night, she had the staff conduct facility wide skin sweeps and one hundred percent of the skin audits were completed. Staff B had performed the skin check for Resident #3 and did not identify the right . . . The DON further stated the nurse feels bad that she missed the identification of and the DON was made aware the surveyor had previously interviewed the nurse and that she confirmed no knowledge of a . . . or . . . to the resident's right . . .</p> <p>The facility nurse failed to properly assess Resident #3's . . . to identify the existing . . .</p> <p>Review of the . . . Care Provider documentation dated . . . documented the following: "Right . . . first, . . . measures 1.6 cm in length, 2 cm in width and 0.2 cm in depth, . . . base 20% . . . Required</p>	N 201		
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N 201	<p>Continued From page 7</p> <p>surgical debridement Treatment _____ and _____ and offload.</p> <p>Post debridement assessment documented no changes from the initial measurements."</p> <p>Interview with the _____ Care Provider conducted on _____ at 2:10 PM revealed the _____ was assessed as a _____ because of the coloration, it looks like a _____ at the base. After questioning the nature of the _____, the provider explained it was a self-inflicting _____, meaning that the resident most likely moved his _____ and hit the area. The provider was made aware the resident is severely _____ and has very limited mobility. The provider stated it is possible he moved his _____ a unit, the _____ could be caused by friction, _____ and understands the possibility the _____ could have been inflicted by pressure.</p> <p>The investigation determined the facility failed to identify the _____ or subsequent open _____ to the resident's right _____, prior to surveyor intervention; the _____ nurse failed to properly assess the _____, documenting erroneous measurements and the staff nurse failed to capture the _____ during skin check assessment completed on _____, the day prior to the surveyor's observation.</p> <p>3. Clinical record review conducted on _____ revealed Resident #1 was admitted to the facility on _____ for rehabilitation after a _____</p> <p>Review of the Initial skin assessment documented the skin was intact, and no evidence of _____</p>	N 201		
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N 201	<p>Continued From page 8</p> <p>Review of the MDS, admission assessment with reference date, documented the resident was assessed as moderately for skills of daily decision making, was at risk for developing and had no on admission.</p> <p>Review of the plan of care dated documented, "The resident is at risk for skin related to/decreased mobility. The interventions included: Encourage and assist resident to minimize pressure to bony prominences as tolerated; Preventative skin treatments as ordered/indicated, as tolerated by resident; Skin checks weekly and as indicated. Report any signs and symptoms of to physician and team as indicated."</p> <p>The record documented Resident #1 developed a to the right heel on There was no stage of the documented. On the nurse documented the resident now has to right and left heel.</p> <p>Review of the Treatment Administration Records (TARs) dated and, the nurses' progress notes and the weekly skin checks failed to provide evidence of preventative measures to minimize to the resident's heels. There was no documentation the resident refused of his heels.</p> <p>The record indicated Resident #1 was transferred to the hospital on</p> <p>Review of the Hospital records, reviewed on, revealed Resident #1 was admitted to</p>	N 201		

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N 201	<p>Continued From page 9</p> <p>the acute care facility on _____ with _____ to the right and left heels.</p> <p>Interview with the WCN conducted on _____ at 12:09 PM revealed that after reviewing his notes, Resident #1 was admitted to the nursing home with no _____, he had a _____ and did not like to turn on his side. On _____, a _____ to the right heel was identified. There were no measurements or stage documented on that date. On _____, the right heel was assessed as a _____, and the left heel had developed a _____. The WCN explained the _____ were unavoidable due to the resident's preference to stay on his _____. The WCN was asked what the facility practices to minimize pressure to the residents' heels were. He responded they have _____, or they use skin prep as another measure if the residents refuse the _____ devices. The WCN confirmed Resident #1 did not have _____ or use of skin prep prior to the development of the _____ and he did not recall if the _____ to the heels resolved prior to hospitalization.</p> <p>The investigation determined that the facility failed to implement preventative measures to minimize the development of _____ for Resident #1. The staff were aware the resident preferred to stay on his _____ due to the _____ in use, there is no documentation of the resident refusal to offload his heels, and the treatment to mitigate _____, with skin prep, was initiated after the first developed on _____.</p> <p>Class III</p>	N 201		

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

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F 000	INITIAL COMMENTS An unannounced Complaint survey, complaint numbers 2025000831, 2025001329 and 2025001493, was conducted on _____ through _____ at Vero Beach Care Center. The facility is not in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Complaint number 2025000831 was substantiated with deficiencies and cited at F684 and F686.	F 000			
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 observation, record review and interview, the facility failed to provide necessary care and services to prevent, identify and properly assess _____, for 1 of 2 sampled residents reviewed for _____ (Resident #3), as evidenced by the facility failed to identify the _____ or subsequent open _____ to the resident's right _____, prior to surveyor intervention; the care nurse failed to properly assess the _____, documenting erroneous measurements and staff nurses failed to capture the _____ during skin check assessment completed on _____, the day prior to the surveyor's observation.	F 684	F684, Quality of Care (1) What corrective action(s) will be accomplished for those residents who found to have been affected by the deficient practice? On _____ resident #3 was immediately assessed by a licensed nurse for any adverse effects related to the alleged deficient practice, none were noted. The Attending Physician and care ARNP were immediately notified, orders for treatment received and		

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

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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 684	<p>Continued From page 1</p> <p>The findings included:</p> <p>Observation of care conducted on at 10:20 AM revealed the Care Nurse (WCN) performed care for Resident #3's left</p> <p>At the end of the treatment, the surveyor asked the reason why the was only applied to the left as the resident was severely on both . The WCN responded that the resident prefers to lay on the left side and that is where the is located, so an is not necessary to the right .</p> <p>The WCN was asked if the resident had any to the right or and replied 'no'. At this time, the resident spoke up and said, yes he had to the right . The WCN then proceeded to inspect the right . An open was noted to the right . below the big , that looked like a that had opened up, with visible depth and yellow . about the size of a dime. The WCN stated he was going to contact the physician for treatment orders and that the provider would evaluate the resident tomorrow (Thursday).</p> <p>Interview with the WCN, conducted upon completion of the care observation, on at approximately 10:30 AM, revealed the nurse had no knowledge of a previous or to the right and stated that he has provided the care to the left but has not inspected the right . He stated the care provider rounds weekly and inspects the resident's skin, so the was not present last</p>	F 684	<p>treatment initiated on .</p> <p>(2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken.</p> <p>A quality review of current residents' skin was completed by the nurse practitioner/designee on to ensure no new skin were noted and required treatment. Any issues identified were immediately corrected.</p> <p>3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur. The Assistant Director of Nursing or designee-initiated education for the current licensed nurses on about Comprehensive Skin Assessment and Areas to monitor on the body that are Susceptible to Newly hired nurses will receive education by the Assistant Director of Nursing or designee related to the following: about Comprehensive Skin Assessment and Areas to Monitor on the Body that are Susceptible to .</p> <p>4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place:</p> <p>Assistant Director of Nursing/ Designee to conduct weekly audits of resident's Skin Assessments 2x weekly for 8 weeks, then 1x weekly for 4 weeks, and then</p>		

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F 684	<p>Continued From page 2</p> <p>Thursday.</p> <p>An interview was conducted with Staff A, Certified Nursing Assistant (CNA), assigned to care for Resident #3, on _____ at 10:37 AM. Staff A stated she has not seen the resident as of yet today, she has a heavy assignment, was attending to other residents, and did not have the resident the day before. Staff A denied knowledge of any _____ or _____ to the right _____.</p> <p>An interview with Staff B, Registered Nurse (RN), conducted on _____ at approximately 10:46 AM, revealed this is her regular hallway assignment, and she is not aware of a _____ or _____ to the resident's right _____.</p> <p>Clinical record review conducted on _____ revealed Resident #3 has diagnoses that included _____ and _____.</p> <p>Review of the Minimum Data Set (MDS), quarterly assessment with reference date of _____, documented the resident was assessed as severely _____ for skills of daily decision making, and has a _____, _____ present on reentry.</p> <p>Review of the care plan, titled, "The resident is at risk for skin _____ related to _____/decreased mobility, multiple sites (left & right _____), _____, left _____, right dorsal _____ and right heel", was initiated on _____ and revised on _____.</p> <p>The plan documented interventions including "patient to have _____ cushion/ _____ positioning device (black) on to be removed when in wheelchair, for skin check, hygiene, shower</p>	F 684	<p>random audits x 1 week for 4 weeks to ensure compliance with _____ Care identification and appropriate treatments provided.</p> <p>The findings of these quality monitoring to be reported to the Quality Assurance/Performance Improvement Committee monthly until substantial compliance has been met.</p>	

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F 684	<p>Continued From page 3</p> <p>and tolerance. To be on in AM/Off in PM. Can be removed for skin check, range of motion and hygiene as ordered and skin checks weekly and as indicated, report any signs of to physician and team as indicated."</p> <p>Review of the weekly skin assessments, the progress notes and the care notes failed to document the presence of a to the right .</p> <p>Review of the Progress notes dated . documented the WCN measured the right noting 1.5 centimeter (cm) in length, 2.0 cm in width, 0 cm in depth. The surveyor's observation validates the newly identified had depth, it was not a superficial , and the noted assessment was not accurate.</p> <p>An interview with the Director of Nursing (DON) conducted on at approximately 12:20 PM, revealed that last night, she had the staff conduct facility wide skin sweeps and one hundred percent of the skin audits were completed. Staff B had performed the skin check for Resident #3 and did not identify the right . The DON further stated the nurse feels bad that she missed the identification of and the DON was made aware the surveyor had previously interviewed the nurse and that she confirmed no knowledge of a . or to the resident's right .</p> <p>The facility nurse failed to properly assess Resident #3's to identify the existing . .</p> <p>Review of the Care Provider documentation dated documented the following:</p>	F 684			

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F 684	<p>Continued From page 4</p> <p>"Right first, measures 1.6 cm in length, 2 cm in width and 0.2 cm in depth, base 20% Required surgical debridement Treatment and and offload. Post debridement assessment documented no changes from the initial measurements."</p> <p>Interview with the Care Provider conducted on at 2:10 PM revealed the was assessed as a because of the coloration, it looks like a at the base. After questioning the nature of the , the provider explained it was a self-inflicting , meaning that the resident most likely moved his and hit the area. The provider was made aware the resident is severely and has very limited mobility. The provider stated it is possible he moved his a unit, the could be caused by friction, and understands the possibility the could have been inflicted by pressure.</p> <p>The investigation determined the facility failed to identify the or subsequent open to the resident's right , prior to surveyor intervention; the nurse failed to properly assess the , documenting erroneous measurements and the staff nurse failed to capture the during skin check assessment completed on , the day prior to the surveyor's observation.</p>	F 684		
F 686 SS=D	<p>Treatment/Svcs to Prevent/Heal CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity</p>	F 686		

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F 686	<p>Continued From page 5</p> <p>§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 observation, record review and interview, the facility failed to provide necessary care and services to prevent and promote healing of _____, for 2 of 2 sampled residents reviewed for _____, Resident #3 and Resident #1.</p> <p>The findings included:</p> <p>Review of the policy, titled, " _____ Care and Treatment", revised _____, documented, in part:</p> <p>"Standard: The purpose of this procedure is to provide guidelines for the care of _____ to promote healing.</p> <p>Guideline: Only staff trained to complete physician orders will complete _____ care and treatments as prescribed.</p> <p>Procedure: Preparation</p> <p>1. Verify that there is a physician's order for this procedure...</p> <p>4. Assess residents _____ level as needed.</p> <p>Equipment and Supplies:</p>	F 686	<p>F686, Treatment/Svc to prevent/ heal</p> <p>1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #1, no longer resides in the facility, discharged on _____ Resident #3, On _____ resident #3 was immediately assessed by a licensed nurse for any adverse effects related to the alleged deficient practice, none were noted. The Attending Physician and _____ care ARNP were immediately notified, orders for treatment received and treatment initiated on _____</p> <p>2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken;</p> <p>A quality review of current residents' skin</p>	

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F 686	<p>Continued From page 6</p> <p>The following equipment and supplies will be necessary when performing this procedure... 12. Assess residents tolerance of care throughout the procedure. 16. Reposition the bed covers. Make the resident comfortable. Use supportive devices as instructed. Documentation: The following information should be recorded in the resident's medical record: 1. The type of care given... 4. Any change in the resident's condition. 5. Any problems or complaints made by the resident related to the procedure. Reporting: 2. Report other information in accordance with facility policy and professional standards practice."</p> <p>1. Observation of care conducted on _____ at 10:20 AM revealed the Care Nurse (WCN) prepared supplies for Resident #3 and explained the floor nurse had previously medicated the resident for _____. The WCN prepared _____ solution, _____, _____, skin prep, _____ and _____ border gauze, the unit manager was present during the observation. Resident #3 was severely _____. It was noted the resident had a pillow between the _____ and a green _____ was in place to the left _____. The nurse performed _____ hygiene, opened all the supplies, forcefully removed the pillow from between the resident's _____. The resident yelled and the WCN explained he had to remove it to do his _____. The WCN then removed the green _____ by lifting the resident's _____ and the resident yelled again. The WCN proceeded to remove the dirty _____, cleansed</p>	F 686	<p>was completed by the _____ nurse practitioner/designee on _____ to ensure no new skin _____ were noted and required treatment. Any issues identified were immediately corrected. 3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not reoccur.</p> <p>On _____, the Assisted Director of Nursing/ designee, initiated education on the components of the Failure to provide necessary care and services to prevent and promote healing of _____, with emphasis on providing treatment to ensure the healing of _____. Newly hired nurses will be educated on the components of Failure to provide necessary care and services to prevent and promote healing of _____, with emphasis on providing treatment to ensure the healing of the _____, by the Assistant Director of Nursing/designee at orientation as part of the systematic changes.</p> <p>4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what _____ quality assurance program will be put in place.</p> <p>The Assistant Director of Nursing/ designee will conduct random audits of 5 resident with _____ to ensure that their treatment and services have been provided according to their Physician Orders, 2x a week for 4 weeks, then 1x</p>	

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F 686	<p>Continued From page 7</p> <p>the area with the solution, and again the resident yelled when the solution was applied. The WCN continued by applying skin prep around the applied the and dry border gauze and reapplied the</p> <p>Interview with the WCN conducted upon completion of the care observation, confirmed the staff failed to perform hygiene after removing the dirty and prior to cleansing the and applying the treatment. The WCN reiterated the resident was medicated for prior to the treatment. The WCN did not acknowledge the resident's tolerance to the treatment.</p> <p>Clinical record review conducted on revealed Resident #3 has diagnoses that included and</p> <p>Review of the Minimum Data Set (MDS), quarterly assessment with reference date of documented the resident was assessed as severely for skills of daily decision making, and has a present on reentry.</p> <p>Review of the care plans, titled "The resident is at risk for skin related to and decreased mobility, initiated on and revised on revealed the plan documented interventions including "patient to have cushion/ positioning device(black) on to be removed for when in wheelchair, for skin check, hygiene, shower and tolerance. To be on in AM/Off in PM. Can be removed for skin check, range of motion and</p>	F 686	<p>week for 4 weeks and then monthly for 1 month to ensure compliance. The findings of these quality monitoring to be reported to the Quality Assurance/Performance Improvement Committee monthly until substantial compliance has been met.</p>	

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F 686	<p>Continued From page 8</p> <p>hygiene as ordered and skin checks weekly and as indicated. Report any signs of to physician and team as indicated."</p> <p>Review of the Physician's order dated . documented " care left lateral . fifth: Cleanse with cleanser - dry, apply skin prep to peri apply . 0.1%, cover with border gauze, every Tuesday, Thursday and Saturday. PLACE GREEN</p> <p>The observation determined the WCN failed to follow policies and procedures during the treatment administration to promote healing and minimize risk of</p> <p>2. Clinical record review conducted on revealed Resident #1 was admitted to the facility on for rehabilitation after a</p> <p>Review of the Initial skin assessment documented the skin was intact, and no evidence of .</p> <p>Review of the MDS, admission assessment with reference date . documented the resident was assessed as moderately for skills of daily decision making, was at risk for developing . and had no on admission.</p> <p>Review of the plan of care dated documented, "The resident is at risk for skin related to /decreased mobility. The interventions included: Encourage and assist resident to minimize pressure to bony</p>	F 686			

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F 686	<p>Continued From page 9</p> <p>prominences as tolerated; Preventative skin treatments as ordered/indicated, as tolerated by resident; Skin checks weekly and as indicated. Report any signs and symptoms of _____ to physician and _____ team as indicated."</p> <p>The record documented Resident #1 developed a _____ to the right heel on _____. There was no stage of the _____ documented. On _____ the nurse documented the resident now has _____ to right and left heel.</p> <p>Review of the Treatment Administration Records (TARs) dated _____ and _____, the nurses' progress notes and the weekly skin checks failed to provide evidence of preventative measures to minimize _____ to the resident's heels. There was no documentation the resident refused _____ of his heels.</p> <p>The record indicated Resident #1 was transferred to the hospital on _____.</p> <p>Review of the Hospital records, reviewed on _____, revealed Resident #1 was admitted to the acute care facility on _____ with _____ to the right and left heels.</p> <p>Interview with the WCN conducted on _____ at 12:09 PM revealed that after reviewing his notes, Resident #1 was admitted to the nursing home with no _____, he had a _____, and did not like to turn on his side. On _____, a _____ to the right heel was identified. There were no measurements or stage documented on that date. On _____, the right heel was assessed</p>	F 686			

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F 686	<p>Continued From page 10</p> <p>as a . . . and the left heel had developed a The WCN explained the . . . were unavoidable due to the resident's preference to stay on his The WCN was asked what the facility practices to minimize pressure to the residents' heels were. He responded they have , or they use skin prep as another measure if the residents refuse the . . . devices. The WCN confirmed Resident #1 did not have . . . or use of skin prep prior to the development of the . . . and he did not recall if the . . . to the heels resolved prior to hospitalization.</p> <p>The investigation determined that the facility failed to implement preventative measures to minimize the development of . . . for Resident #1. The staff were aware the resident preferred to stay on his . . . due to the . . . in use, there is no documentation of the resident refusal to offload his heels, and the treatment to mitigate . . . , with skin prep, was initiated after the first . . . developed on . . .</p>	F 686			