

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 93105	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/24/2025
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NAME OF PROVIDER OR SUPPLIER PALM GARDEN OF VERO BEACH	STREET ADDRESS, CITY, STATE, ZIP CODE 1755 37TH STREET VERO BEACH, FL 32960
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N 000	<p>INITIAL COMMENTS</p> <p>A relicensure survey was conducted on _____ at Palm Garden of Vero Beach. The facility had deficiencies at the time of the survey.</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 ensure timely and appropriate quality of care for 6 of 14 sampled residents reviewed for medications, _____, and _____ as evidenced by failure to timely obtain and administer _____ and _____ for Resident #24, failure to treat a _____ per physician order for Resident#102, failure to obtain a physician order for _____ care prior to treatment for Resident #517, failure to follow physician order to not wear a sock or provide education to Resident #100 who had a _____, and failure to ensure care and services for the _____ for Residents #162 and #11.</p> <p>The findings included:</p> <p>1. Review of the record revealed Resident #24 was admitted to the facility on _____. Review</p>	N 201	<p>Resident #24 completed her _____ on _____ and per the podiatrist on _____ she had no signs of _____. Per the orthopedic surgeon on _____ the resident _____ healed and there were no concerns documented. The resident received her _____ as ordered on _____ and discharged from the center on _____.</p> <p>Resident #102 will have his _____ care completed per the physician orders.</p> <p>The _____ for resident #517 has resolved. Resident #517 will have his _____ care completed per physician orders.</p> <p>Resident #100 receives necessary treatment and services, consistent with</p>	

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

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N 201	<p>Continued From page 1</p> <p>of the current Minimum Data Set (MDS) assessment dated _____ documented the resident had a () score of 15, on a 0 to 15 scaled, indicating the resident was _____.</p> <p>During an interview on _____ Resident #24 stated she missed a dose of _____ and had trouble getting her _____ upon admission to the facility.</p> <p>Review of physician orders revealed the following:</p> <p>a) As of _____, the resident was ordered the _____ Lumigan at bedtime for _____.</p> <p>b) As of _____, the resident was ordered the _____ four times daily for _____.</p> <p>c) As of _____, the resident was ordered the _____ twice daily for _____.</p> <p>d) As of _____, the resident was ordered the _____ 2 grams () daily for _____.</p> <p>Review of the _____ Medication Administration Record (MAR) revealed the following:</p> <p>a) The Lumigan _____ was not administered until _____ as staff were "awaiting delivery", thus missing two doses. During an interview on _____ at 11:23 AM, the Unit Manager stated the _____ was delivered to the facility on _____ and that she did not know why it was not administered timely.</p> <p>b) The _____ was not administered until _____ as staff were "awaiting delivery", thus missing five doses. The Unit Manager stated this _____ was also delivered to the facility on _____ and that she did not know why it was not administered timely.</p>	N 201	<p>professional stands of practice to promote healing, prevent _____ and prevent new _____ from developing.</p> <p>The resident #162 had her _____ changed and _____ recollected on _____. Her _____ bag will be anchored as required. Her _____ will be ordered in a timely manner.</p> <p>Resident #11 will have her _____ completed per the center's process.</p> <p>Residents with _____ and _____ orders were audited on _____ to ensure that their _____ or _____ were administered per physician orders. No other residents were affected by this alleged deficient practice.</p> <p>Residents with _____ will have their care completed per physician orders. _____ care orders were audited on _____ to ensure no other residents were affected by this alleged deficient practice.</p> <p>Residents with _____ were observed on _____ to ensure proper control practices were followed. No residents were affected by this alleged deficient practice.</p> <p>Residents with _____ or _____ will have _____ or care observations completed by the Director of Education/designee to ensure clinical competency for this standard of practice. Any lack of competency by the team member will be _____.</p>	

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N 201	<p>Continued From page 2</p> <p>c) The _____, was documented as administered as of _____ in the morning, related to awaiting delivery, which would indicate the resident missed three doses. But during the continued interview, the Unit Manager stated the _____ was not delivered to the facility until _____.</p> <p>d) The _____ was administered as ordered on _____, but was not administered on _____, as the medication was "on order." The Unit Manager confirmed this _____ was available in their emergency stock and should have been administered.</p> <p>Review of the _____ MAR revealed the following:</p> <p>e) The _____, were not administered on _____ and _____, as evidenced by a blank in the MAR, with no explanation provided.</p> <p>f) The _____ was not provided on _____, as it was "on order." During the continued interview, the Unit Manager confirmed the _____ had been available in the emergency supply.</p> <p>2. Review of the record revealed Resident #162 was admitted to the facility on _____. Review of the current physicians' orders documented the resident had an _____ and staff were to flush the _____ as needed. Review of the current care plan initiated on _____ documented the resident was at risk for complications related to the use of an _____. Interventions included to anchor the _____ and to irrigate it as ordered.</p> <p>Review of a _____ report revealed _____ was collected on _____ for the test. The results of a</p>	N 201	<p>corrected immediately.</p> <p>Residents pending _____ results had their results reviewed on _____ ensure timely ordering of _____. Any results with a delay in treatment will result in a physician notification.</p> <p>The director of education or designee will complete the following educations for nursing team members by _____.</p> <p>Licensed nurses will be educated on following physician orders for _____ care, _____ and _____.</p> <p>b. Licensed nurses will be educated to obtain a _____ care order prior to providing a treatment.</p> <p>c. Licensed nurses will be educated on the signs and symptoms of a _____ and to report laboratory results timely to the provider.</p> <p>d. Nursing team members will be educated on proper _____ control procedures regarding _____.</p> <p>e. Certified nursing assistants will be educated on proper _____ procedures.</p> <p>_____ orders will be audited for administration per physician orders weekly x4 weeks and monthly x12 months by the preventionist/designee.</p> <p>_____ orders will be audited for administration per physician orders weekly x4 weeks and monthly x12 months by the DCS/designee.</p> <p>_____ care treatments will be audited for</p>		

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N 201	<p>Continued From page 3</p> <p>positive were reported to the facility on with the completed culture on indicating appropriate to use. The was not reviewed until at which time an was ordered.</p> <p>An observation on at 11:26 AM revealed the bag hanging on the bedside. Cloudy was noted in the tubing. During a subsequent observation on at 9:15 AM, care was observed with Staff G and Staff H, both Certified Nursing Assistants (CNA). Observation of the tubing revealed continued cloudy . Photographic Evidence Obtained. During the care, an anchor was noted on the resident's , but the tubing was not secure. When staff turned the resident onto her right side, with the bag on her left side, the tubing was pulled tightly. After the care, when asked the use of the anchor, Staff H stated it was to keep the tubing from pulling. Staff G attempted to hook the into the anchor at the junction, in order to secure it, but Staff H told Staff G that was not correct, and put it as it was, leaving the loose and freely moving.</p> <p>During an observation on at 3:43 PM, Staff I, Licensed Practical Nurse (LPN), was unaware of how to utilize the anchor, but agreed the tubing was not secured. When asked if she had assessed the that day, the LPN stated she had and the was cloudy that morning, and agreed it still was. When asked what she should do if the was cloudy, the LPN stated she should notify the physician but had not done so.</p> <p>During an interview on at 9:58 AM, when asked what she would expect a nurse to do</p>	N 201	<p>accuracy weekly x4 weeks and months x12 months by the DCS/designee.</p> <p>results will be audited to ensure timely review and ordering of an weekly x4 weeks and monthly x12 months by the Director of clinical services/designee.</p> <p>anchors will be audited weekly x4 weeks and monthly x12 months by the Director of clinical services/designee.</p> <p>provided to residents with be audited weekly x4 weeks and monthly x12 months by the director of clinical services/designee.</p> <p>All audits will be brought to the QAPI committee monthly for review.</p>	

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N 201	<p>Continued From page 4</p> <p>if a resident's _____ had cloudy _____, the Unit Manager stated the nurse should try to flush the _____, encourage fluids, and call the physician if it persists. The Unit Manager stated she did receive an order for a _____ after the surveyor had asked the nurse about the cloudy _____ the previous afternoon. When asked the process for reviewing the results, the Unit Manager stated the labs are uploaded by the lab into their electronic medical record and the lab will call the facility with any critical results. The Unit Manager explained that both the nurses and physician or nurse practitioner are responsible for reviewing the labs. During a side-by-side review of the record, the Unit Manager was made aware of the _____ of _____ and delay of _____. The Unit Manager had no reason for the delay.</p> <p>3. Clinical record review revealed Resident #100 was admitted to the facility on _____ and again on _____, with diagnoses that included _____. The admission Minimum Data Set (MDS) assessment, referenced on _____, recorded a _____ (_____) score of 11, indicating Resident #100 was moderately _____. This MDS indicated no _____, or behavior concerns and documented the resident was dependent on assistance for lower body _____, and putting on or taking off footwear.</p> <p>Review of the care plan, revised on _____, noted Resident #100 had a pressure injury on the left heel. Interventions on the care plan included floating the heels while in bed as tolerated by the resident and treatments as ordered.</p> <p>Review of Certified Nursing Assistants (CNA) tasks revealed "no sock on the left _____."</p>	N 201		
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N 201	<p>Continued From page 5</p> <p>An additional review of the clinical record indicated a physician order dated _____ to apply _____ to the left heel every Tuesday, Thursday, and Friday, allowing it to air dry for care management. The order specifically stated, "no sock to left _____ ; _____."</p> <p>Review of the doctor's _____ care evaluation dated _____ included the following recommendations: off-load _____ and _____ in bed. Additionally, place a heel elevator or pillows behind the _____ (_____ to the popliteal fossa) to elevate the heels from making contact with the bed surface.</p> <p>On _____ at 10:33 AM, an observation was conducted on Resident #100. She was found lying in bed with her heels positioned directly on the bed, not _____ . Her heel-protector were on the floor beneath the bed, and she stated, "My heels hurt."</p> <p>On _____, at 11:56 AM, Resident #100 was observed sitting at the edge of her bed, wearing socks and placing her _____ directly on the floor, not _____ them. She was talking to her visitor, who was beside her, labeling new socks that had been brought in. Two heel-protector _____ were on the floor next to the bed.</p> <p>On _____ at noon, Staff A, _____ Care Nurse (WCN), conducted care for the left heel applying _____ to the open area. Staff A assessed the resident for _____, and the resident expressed that her heels hurt. After the care, Staff A asked if Resident #100 wanted to wear the new socks her friend had brought in. The resident responded, "Yes." Staff A then applied the socks to the resident's _____ and retrieved the _____ from the floor,</p>	N 201		
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N 201	<p>Continued From page 6</p> <p>putting them on the resident's . This practice did not follow the physician's order to allow the to air dry. Staff A also failed to provide guidance or education regarding the risks of wearing socks in the affected area and the importance of allowing the to air dry.</p> <p>At 12:14 PM, the surveyor overheard the visitor telling Resident #100, "The socks are not good for the bad ; you should take them off."</p> <p>At 12:32 PM, another observation was conducted, and Resident #100 was still wearing the socks and the</p> <p>On at 12:20 PM, Staff C, the assigned CNA, was interviewed. She stated that when she came in, she observed Resident #100 wearing socks and commented, "Maybe the previous shift put them on."</p> <p>On at 1:13 PM, Resident #100 was sitting in bed, still wearing socks and the heel-protector</p> <p>On at 2:02 PM, an interview with Staff A (WCN) revealed that when asked why she put socks on the resident's after the care, she stated the resident preferred to have them on. When the surveyor pointed out that the physician's order specifically indicated "no sock on the left ", Staff A agreed upon seeing the order and acknowledged the care doctor preferred the socks not to be applied. The surveyor then asked why she had not provided guidance or education to the resident about the risks of wearing socks. Staff A agreed that she should have done so. After the surveyor's intervention, Staff A spoke to the resident, stating, "Remember how the socks stick to the . The doctor does not want them on." The resident complied and allowed the nurse to remove the</p>	N 201		
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N 201	<p>Continued From page 7</p> <p>socks.</p> <p>4. Clinical record review revealed Resident # 11 was admitted to the facility on _____ with diagnoses that included non-_____. The quarterly Minimum Data Set (MDS) assessment reference date was _____ documented a (_____) score of 06, indicating Resident # 11 was severely _____ . This MDS did not record any _____ or behavior concerns. It was documented that she was dependent and required assistance with toileting hygiene, personal hygiene, and toilet transfers, and was frequently _____ of _____, indicating a loss of control.</p> <p>The records included a care plan added to the revised plan dated _____. This care plan documented Resident #11 had related to _____ mobility, with her status potentially varying due to her diagnosis of _____. It also noted that she was frequently _____ of _____ and had the potential for complications secondary to the _____.</p> <p>On _____, a _____ sample was collected, and the _____ results showed a positive (_____), which was reported to the facility by the lab on the same day. Further recollection of _____ was suggested. On _____ the facility was able to straight _____ the resident after several attempts due to her resistance. The results from this _____ collection were reported on _____, confirming the presence of a _____. On _____, a physician order for the _____ 100 mg to be taken orally twice a day for seven days, was initiated.</p>	N 201		

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N 201	<p>Continued From page 8</p> <p>On _____ at 11:03 AM, _____ care was initiated by Staff B, Certified Nursing Assistant (CNA). Staff B placed a large towel in the bathroom sink, allowed the water to run until the towel was saturated, and then applied soap. After retrieving the wet towel and squeezing some water out, she approached the resident and brusquely instructed her to "open her _____." She then poured water from the towel onto the resident's private area and used wet wipes to clean the _____ area and the top of the pubic bone, but did not provide care to the external structures.</p> <p>Staff B repeated the process, squeezing more water from the towel onto the pubic area and cleaning it with wet wipes. She then instructed the resident to turn, which the resident did without resistance. Staff B squeezed water from the towel onto the resident's _____ and wiped them with the wet towel, then used wet wipes for additional cleaning. Without drying the _____ area, she applied protective _____ cream to the _____ and _____ area, then put on a new adult _____ brief and secured it. The care was completed at 11:09 AM, and Staff B stated, "She was done."</p> <p>Later, at 11:56 AM on _____, the Director of Nursing (DON) and the _____ Control Preventionist were interviewed regarding how the care was provided to resident #11. The surveyor demonstrated the process Staff B had used during the care. The DON and the _____ Control Preventionist agreed that the process was improperly executed.</p> <p>5. Record review revealed Resident #102 was admitted to the facility on _____. Review of current Minimum Data Sheet (MDS) assessment dated _____, documented a Brief Interview for</p>	N 201		

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N 201	<p>Continued From page 9</p> <p>Mental Status score of 15, on a 0-15 scale indicating no</p> <p>An observation on at 11:45 AM revealed Resident #102 sitting in the wheelchair and on his right lateral lower, he had a, that was uncovered, with bloody drainage leaking on his sock and on a gauze dated which was below the</p> <p>Review of the physician's order, dated instructed the staff to cleanse self-inflicted skin areas to the right lateral lower with normal (salt solution), dry, apply xeroform (vaseline gauze), gauze, and wrap with kerlix (bulky gauze) on every night shift.</p> <p>An observation on at 10:35 AM, revealed Resident #102 was observed sitting in the wheelchair in the room. There was a to right lateral, that was uncovered, with dry bloody drainage to the area. There was a gauze, that was not dated, below the</p> <p>An observation on at 12:11 PM revealed Resident #102 sitting in the wheelchair with his lunch tray in front of him. There was a gauze dated to Resident #102's right lower and a with bloody drainage was observed above the gauze</p> <p>During an interview on at 12:19 PM, when asked if the, that was without a, was the that had the ordered treatment or if it was a different underneath the. Staff F, Licensed Practical Nurse (LPN), stated, "I'm not sure, but I know he scratches his. I will change the and look, because his does need attention."</p>	N 201		

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N 201	<p>Continued From page 10</p> <p>An observation on _____ at 3:23 PM revealed Staff F removed the _____ from Resident #102's right lower _____. Staff F removed a rolled gauze _____, gauze _____, and xeroform. The area on the right lateral lower _____ that was covered, was slightly red and the skin was intact. Staff F stated, "The resident is saying that the gauze is itchy on his skin and that's why he is scratching his _____. I am not going to cover the area that I uncovered. I will just apply lotion to the area, but I will cover the other area with a bordered gauze after I clean it up."</p> <p>During an interview on _____ at 3:42 PM, when asked did you perform _____ care on Resident# 102, the _____ Care Nurse stated, "No, the nurses do." The _____ care nurse briefly walked away, returned and stated, "Resident #102 said the rolled gauze is itching him. I will put a call out to the ARNP (Advanced Registered Nurse Practitioner) for a new order to apply bordered gauze. He often has an issue with scratching."</p> <p>Review of an order dated _____, instructed staff to cleanse area to right lateral _____ with normal _____ dry, apply xeroform and cover with bordered gauze _____.</p> <p>An observation on _____ at 9:51 AM revealed Resident #102 sitting in the wheelchair with his right _____ elevated. There was rolled gauze on his right _____ secured with tape and dated _____. When asked if the nurse just did _____ care to his right _____, Resident #102 stated, "Yes."</p> <p>During an interview on _____ at 10:16 AM, when asked, are you the nurse who performed the _____ care on Resident #102, Staff E, LPN,</p>	N 201		

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N 201	<p>Continued From page 11</p> <p>stated "Yes, this morning. The _____ was _____, because he scratches." When asked, did you remove the same type of _____ from Resident #102's right _____ that you reapplied Staff E stated, "Yes."</p> <p>6. Record review for Resident #517 revealed the resident was admitted to the facility on _____ with a diagnosis that included right ankle requiring surgical repair.</p> <p>Review of the Hospital History and Physical dated _____ documented, in part, that Resident #517 "landed on _____ and left _____ with severe _____ in his right ankle". Review of the admission MDS assessment, which was in progress, documented Resident #517 had a _____ score of 15, indicating the resident was _____.</p> <p>Review of the Admission Skin Assessment dated _____ documented a _____ to the left _____.</p> <p>Review of the Skin Observation documentation on the Certified Nursing Assistant (CNA) task list from _____ at 2:01 PM revealed Resident #517 had a scratch and _____.</p> <p>Review of the physician's orders did not include an order for the left _____ for the resident.</p> <p>During an observation conducted on _____ at 10:00 AM, the resident was sitting in a wheelchair, awake and alert and oriented. It was noted that the left _____ was covered with a dry and intact _____ dated _____.</p> <p>During an observation conducted on _____ at 12:17 PM, Resident #517 was sitting in room, awake, alert and oriented. The resident had a new dry and intact _____ on his left _____.</p>	N 201		
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Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 93105	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/24/2025
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NAME OF PROVIDER OR SUPPLIER PALM GARDEN OF VERO BEACH	STREET ADDRESS, CITY, STATE, ZIP CODE 1755 37TH STREET 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 201	<p>Continued From page 12</p> <p>dated " 7a/7p". When the resident was asked what happened to his , he stated "that happened when I two weeks ago. It's nothing really". When asked who applied the _ to his left , the resident replied, "someone here and they put something on it" but the resident was unable to provide a name of the caregiver.</p> <p>During an interview on at 3:30 PM, Staff D, LPN, stated she did not have to perform any _ changes today for any of her assigned residents. She stated, "it was all already done today".</p> <p>An interview conducted on at 3:38 PM with the Care Nurse (WCN) who stated that she did not do care for Resident #517. The WCN stated the nurses do care _ on Monday's, Wednesday's and Friday's.</p> <p>During a side-by-side review of the record and interview on at 4:00 PM with the Seaway Unit Manager (UM), she confirmed the lack of a physician order for left care _ changes. The UM reviewed the skin assessment documentation on which identified a left tear and agreed that there should be an order.</p> <p>Class III</p>	N 201		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105592	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2025
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F 000	INITIAL COMMENTS	F 000			
F 684 SS=D	<p>A recertification survey was conducted on _____ through _____ at Palm Garden of Vero Beach. The facility is not in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.</p> <p>Quality of Care CFR(s): 483.25</p> <p>§ 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:</p> <p>Based on observation, record review, and interview, the facility failed to ensure timely and appropriate quality of care for 3 of 11 sampled residents reviewed for medications and _____ as evidenced by the failure to timely obtain and administer _____ and _____ for Resident #24, failure to treat a _____ per physician order for Resident #102, and failure to obtain a physician order for _____ care prior to treatment for Resident #517.</p> <p>The findings included:</p> <p>1. Record review revealed Resident #24 was admitted to the facility on _____. Review of the current Minimum Data Set (MDS) assessment dated _____ documented the resident had a _____ (_____) score of _____.</p>	F 684	<p>Resident #24 completed her _____ on _____ and per the podiatrist on _____ she had no signs of _____. Per the orthopedic surgeon on _____ the residents _____ healed and there were no concerns documented. The resident received her _____ as ordered on _____ and discharged from the center on _____.</p> <p>Resident #102 will have his _____ care completed per the physician orders.</p> <p>The _____ for resident #517 has resolved. Resident #517 will have his _____ care completed per physician orders.</p>		

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 684	<p>Continued From page 1</p> <p>15, on a 0 to 15 scaled, indicating the resident was _____</p> <p>During an interview on _____ Resident #24 stated she missed a dose of _____ and had trouble getting her _____ upon admission to the facility.</p> <p>Review of physician orders revealed the following:</p> <p>a) As of _____, the resident was ordered the _____ Lumigan at bedtime for _____</p> <p>b) As of _____, the resident was ordered the _____ four times daily for _____</p> <p>c) As of _____, the resident was ordered the _____ twice daily for _____</p> <p>d) As of _____, the resident was ordered the _____ 2 grams _____ () daily for _____</p> <p>Review of the _____ Medication Administration Record (MAR) revealed the following:</p> <p>a) The Lumigan _____, was not administered until _____ as staff were "awaiting delivery", thus missing two doses. During an interview on _____ at 11:23 AM, the Unit Manager stated the _____ was delivered to the facility on _____ and that she did not know why it was not administered timely.</p> <p>b) The _____, was not administered until _____ as staff were "awaiting delivery", thus missing five doses. The Unit Manager stated this _____ was also delivered to the facility on _____ and that she did not know why it was not administered timely.</p> <p>c) The _____, was documented as administered as of _____ in the morning,</p>	F 684	<p>Residents with _____ and _____ orders were audited on _____ to ensure that their _____ or _____ were administered per physician orders. No other residents were affected by this alleged deficient practice.</p> <p>Residents with _____ will have their _____ care completed per physician orders. _____ care orders were audited on _____ to ensure no other residents were affected by this alleged deficient practice.</p> <p>Licensed nurses will be educated on following physician orders for _____ care, _____ and _____ by the Director of Education/designee.</p> <p>Licensed nurses will be educated to obtain a _____ care order prior to providing a treatment by the Director of Education/designee.</p> <p>_____ orders will be audited for administration per physician orders weekly x4 weeks and monthly x12 months by the _____ preventionist/designee.</p> <p>_____ orders will be audited for administration per physician orders weekly x4 weeks and monthly x12 months by the DCS/designee.</p> <p>_____ care treatments will be audited for accuracy weekly x4 weeks and months x12 months by the DCS/designee.</p> <p>All audits will be brought to QAPI monthly</p>		

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F 684	<p>Continued From page 2</p> <p>related to awaiting delivery, which would indicate the resident missed three doses. But during the continued interview, the Unit Manager stated the was not delivered to the facility until</p> <p>d) The was administered as ordered on , but was not administered on , as the medication was "on order." The Unit Manager confirmed this was available in their emergency stock and should have been administered.</p> <p>Review of the , MAR revealed the following:</p> <p>e) The , were not administered on and , as evidenced by a blank in the MAR, with no explanation provided.</p> <p>f) The was not provided on , as it was "on order." During the continued interview, the Unit Manager confirmed the had been available in the emergency supply.</p> <p>2. Record review revealed Resident #102 was admitted to the facility on . Review of current Minimum Data Sheet (MDS) assessment dated , documented a score of 15, on a 0-15 scale indicating no .</p> <p>An observation on at 11:45 AM revealed Resident #102 sitting in the wheelchair and on his right lateral lower , he had a , that was uncovered, with bloody drainage leaking on his sock and on a gauze dated which was below the</p> <p>Review of the physician's order, dated</p>	F 684	for review.		

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F 684	<p>Continued From page 3</p> <p>instructed the staff to cleanse self-inflicted skin areas to the right lateral lower [redacted] with normal (salt solution), [redacted] dry, apply xeroform (vaseline gauze), gauze [redacted] and wrap with kerlix (bulky gauze [redacted]) on every night shift.</p> <p>An observation on [redacted] at 10:35 AM, revealed Resident #102 was observed sitting in the wheelchair in the room. There was a [redacted] to right lateral [redacted], that was uncovered, with dry bloody drainage to the area. There was a gauze [redacted], that was not dated, below the [redacted].</p> <p>An observation on [redacted] at 12:11 PM revealed Resident #102 sitting in the wheelchair with his lunch tray in front of him. There was a gauze [redacted] dated [redacted] to Resident #102's right lower [redacted] and a [redacted] with bloody drainage was observed above the gauze [redacted].</p> <p>During an interview on [redacted] at 12:19 PM, when asked if the [redacted], that was without a [redacted], was the [redacted] that had the ordered treatment or if it was a different [redacted] underneath the [redacted]. Staff F, Licensed Practical Nurse (LPN), stated, "I'm not sure, but I know he scratches his [redacted]. I will change the [redacted] and look, because his [redacted] does need attention."</p> <p>An observation on [redacted] at 3:23 PM revealed Staff F removed the [redacted] from Resident #102's right lower [redacted]. Staff F removed a rolled gauze [redacted], gauze [redacted], and xeroform. The area on the right lateral lower [redacted] that was covered, was slightly red and the skin was intact. Staff F stated, "The resident is saying that the gauze is itchy on his skin and that's why he is scratching his [redacted]. I am not going to cover the [redacted]."</p>	F 684			

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F 684	<p>Continued From page 4</p> <p>area that I uncovered, I will just apply lotion to the area, but I will cover the other area with a bordered gauze after I clean it up."</p> <p>During an interview on _____ at 3:42 PM, when asked did you perform _____ care on Resident# 102, the _____ Care Nurse stated, "No, the nurses do." The _____ care nurse briefly walked away, returned and stated, "Resident #102 said the rolled gauze is itching him. I will put a call out to the ARNP (Advanced Registered Nurse Practitioner) for a new order to apply bordered gauze. He often has an issue with scratching."</p> <p>Review of an order dated _____, instructed staff to cleanse area to right lateral _____ with normal _____, dry, apply xeroform and cover with bordered gauze _____.</p> <p>An observation on _____ at 9:51 AM revealed Resident #102 sitting in the wheelchair with his right _____ elevated. There was rolled gauze on his right _____ secured with tape and dated _____. When asked if the nurse just did _____ care to his right _____, Resident #102 stated, "Yes."</p> <p>During an interview on _____ at 10:16 AM, when asked, are you the nurse who performed the _____ care on Resident #102, Staff E, LPN, stated "Yes, this morning. The _____ was _____, because he scratches." When asked, did you remove the same type of _____ from Resident #102's right _____ that you reapplied Staff E stated, "Yes."</p> <p>3. Record review for Resident #517 revealed the resident was admitted to the facility on _____ with a diagnosis that included right ankle _____.</p>	F 684			

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F 684	<p>Continued From page 5 requiring surgical repair.</p> <p>Review of the Hospital History and Physical dated _____ documented, in part, that Resident #517 "landed on _____ and left _____ with severe _____ in his right ankle". Review of the admission MDS assessment, which was in progress, documented Resident #517 had a _____ score of 15, indicating the resident was _____.</p> <p>Review of the Admission Skin Assessment dated _____ documented a _____ to the left _____.</p> <p>Review of the Skin Observation documentation on the Certified Nursing Assistant (CNA) task list from _____ at 2:01 PM revealed Resident #517 had a scratch and _____.</p> <p>Review of the physician's orders did not include an order for the left _____ for the resident.</p> <p>During an observation conducted on _____ at 10:00 AM, the resident was sitting in a wheelchair, awake and alert and oriented. It was noted that the left _____ was covered with a dry and intact _____ dated _____.</p> <p>During an observation conducted on _____ at 12:17 PM, Resident #517 was sitting in room, awake, alert and oriented. The resident had a new dry and intact _____ on his left _____ dated "7a/7p". When the resident was asked what happened to his _____, he stated "that happened when I _____ two weeks ago. It's nothing really". When asked who applied the _____ to his left _____, the resident replied, "someone here and they put something on it" but the resident was unable to provide a name of the caregiver.</p>	F 684			

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F 684	Continued From page 6 During an interview on _____ at 3:30 PM, Staff D, LPN, stated she did not have to perform any _____ changes today for any of her assigned residents. She stated, "It was all already done today". An interview conducted on _____ at 3:38 PM with the _____ Care Nurse (WCN) who stated that she did not do _____ care for Resident #517. The WCN stated the nurses do _____ care _____ on Monday's, Wednesday's and Friday's. During a side-by-side review of the record and interview on _____ at 4:00 PM with the Seaway Unit Manager (UM), she confirmed the lack of a physician order for left _____ care _____ changes. The UM reviewed the skin assessment documentation on _____ which identified a left _____ tear and agreed that there should be an order.	F 684			
F 686 SS=D	Treatment/Svcs to Prevent/Heal CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Based on the comprehensive assessment of a resident, the facility must ensure that- (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 (ii) A resident with _____ receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent _____ and prevent _____	F 686			

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F 686	<p>Continued From page 7</p> <p>new from developing.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, interviews, and record reviews, the facility failed to physicians' order were followed to avoid wearing socks to allow the to air dry; failed to provide guidance and education regarding the risk of using socks in the affected area; and failed to follow control practices, as evidenced by using items placed on the floor, for 1 of 5 sampled residents reviewed for care and management, Resident #100.</p> <p>The findings included:</p> <p>Clinical record review revealed Resident #100 was admitted to the facility on and again on , with diagnoses that included . The admission Minimum Data Set (MDS) assessment, referenced on recorded a () score of 11, indicating Resident #100 was moderately . This MDS indicated no , or behavior concerns and documented the resident was dependent on assistance for lower body , and putting on or taking off footwear.</p> <p>Review of the care plan, revised on , noted Resident #100 had a pressure injury on the left heel. Interventions on the care plan included floating the heels while in bed as tolerated by the resident and treatments as ordered.</p> <p>Review of Certified Nursing Assistants (CNA) tasks revealed "no sock on the left ." An additional review of the clinical record indicated a physician order dated to apply to the left heel every Tuesday,</p>	F 686	<p>Resident #100 receives necessary treatment and services, consistent with professional stands of practice to promote healing, prevent and prevent new from developing. Res #100 was educated on wearing socks and agreed to follow care recommendations. Res # 100 has adequate pillows and to off-load heals when in bed or when heels are in a dependent position. Nursing team members will remind res#100 to keep heels off-loaded as recommended during care and daily interactions.</p> <p>care orders were audited on to ensure no other residents were affected by this alleged deficient practice. Residents with were observed on to ensure proper control practices were followed. No residents were affected by this alleged deficient practice.</p> <p>Licensed nurses will be educated to follow physician orders related to care by the Director of Education/designee.</p> <p>Nursing team members will educated on proper control procedures regarding by the Director of Education/designee.</p> <p>care orders will be audited to ensure they are completed per physician</p>	

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F 686	<p>Continued From page 8</p> <p>Thursday, and Friday, allowing it to air dry for care management. The order specifically stated, "no sock to left ; ."</p> <p>Review of the doctor's care evaluation dated included the following recommendations: off-load and in bed. Additionally, place a heel elevator or pillows behind the (to the popliteal fossa) to elevate the heels from making contact with the bed surface.</p> <p>On at 10:33 AM, an observation was conducted on Resident #100. She was found lying in bed with her heels positioned directly on the bed, not . Her heel-protector were on the floor beneath the bed, and she stated, "My heels hurt."</p> <p>On , at 11:56 AM, Resident #100 was observed sitting at the edge of her bed, wearing socks and placing her directly on the floor, not . them. She was talking to her visitor, who was beside her, labeling new socks that had been brought in. Two heel-protector were on the floor next to the bed.</p> <p>On at noon, Staff A, Care Nurse (WCN), conducted care for the left heel , applying to the open area. Staff A assessed the resident for , and the resident expressed that her heels hurt. After the care, Staff A asked if Resident #100 wanted to wear the new socks her friend had brought in. The resident responded, "Yes." Staff A then applied the socks to the resident's and retrieved the from the floor, putting them on the resident's . This practice did not follow the physician's order to allow the</p>	F 686	<p>orders weekly x4 weeks and monthly x12 months by the Director of Clinical Services/designee.</p> <p>will be audited for proper control placement weekly x4 weeks and monthly x12 months by the Director of Clinical Services/designee.</p> <p>All audits will be brought to the QAPI committee monthly for review.</p>		

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F 686	<p>Continued From page 9</p> <p>to air dry. Staff A also failed to provide guidance or education regarding the risks of wearing socks in the affected area and the importance of allowing the to air dry. At 12:14 PM, the surveyor overheard the visitor telling Resident #100, "The socks are not good for the bad ; you should take them off." At 12:32 PM, another observation was conducted, and Resident #100 was still wearing the socks and the</p> <p>On at 12:20 PM, Staff C, the assigned CNA, was interviewed. She stated that when she came in, she observed Resident #100 wearing socks and commented, "Maybe the previous shift put them on."</p> <p>On at 1:13 PM, Resident #100 was sitting in bed, still wearing socks and the heel-protector</p> <p>On at 2:02 PM, an interview with Staff A (WCN) revealed that when asked why she put socks on the resident's after the care, she stated the resident preferred to have them on. When the surveyor pointed out that the physician's order specifically indicated "no sock on the left ", Staff A agreed upon seeing the order and acknowledged the care doctor preferred the socks not to be applied. The surveyor then asked why she had not provided guidance or education to the resident about the risks of wearing socks. Staff A agreed that she should have done so. After the surveyor's intervention, Staff A spoke to the resident, stating, "Remember how the socks stick to the The doctor does not want them on." The resident complied and allowed the nurse to remove the socks.</p>	F 686		

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F 690 SS=D	<p>/</p> <p>CFR(s): 483.25(e)(1)-(3)</p> <p>§483.25(e) §483.25(e)(1) The facility must ensure that resident who is of and on admission receives services and assistance to maintain unless his or her clinical condition is or becomes such that is not possible to maintain.</p> <p>§483.25(e)(2) For a resident with , based on the resident's comprehensive assessment, the facility must ensure that-</p> <p>(i) A resident who enters the facility without an is not unless the resident's clinical condition demonstrates that was necessary;</p> <p>(ii) A resident who enters the facility with an or subsequently receives one is assessed for removal of the as soon as possible unless the resident's clinical condition demonstrates that is necessary; and</p> <p>(iii) A resident who is of receives appropriate treatment and services to prevent and to restore to the extent possible.</p> <p>§483.25(e)(3) For a resident with fecal , based on the resident's comprehensive assessment, the facility must ensure that a resident who is of receives appropriate treatment and services to restore as much normal function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record</p>	F 690			
			The resident #162 had her		

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F 690	<p>Continued From page 11</p> <p>review, the facility failed to ensure appropriate care and services for 2 of 3 sampled residents, Residents #162 and #11, who had _____ and a history of _____ (____).</p> <p>The findings included:</p> <p>1. Review of the record revealed Resident #162 was admitted to the facility on _____. Review of the current physicians' orders documented the resident had an _____ and staff were to flush the _____ as needed. Review of the current care plan initiated on _____ documented the resident was at risk for complications related to the use of an _____. Interventions included to anchor the _____ and to irrigate it as ordered.</p> <p>Review of a _____ report revealed _____ was collected on _____ for the test. The results of a positive _____ were reported to the facility on _____ with the completed culture on _____ indicating appropriate _____ to use. The _____ was not reviewed until _____ at which time an _____ was ordered.</p> <p>An observation on _____ at 11:26 AM revealed the _____ bag hanging on the bedside. Cloudy _____ was noted in the tubing. During a subsequent observation on _____ at 9:15 AM, _____ care was observed with Staff G and Staff H, both Certified Nursing Assistants (CNA). Observation of the _____ tubing revealed continued cloudy _____. Photographic Evidence Obtained. During the care, a _____ anchor was noted on the resident's _____, but the tubing was not secure. When staff turned the resident onto her right side, with the _____ bag</p>	F 690	<p>changed and recollected on _____ Her _____ bag will be anchored as required. Her _____ will be ordered in a timely manner.</p> <p>Resident #11 will have her _____ completed per the center's process.</p> <p>Residents with _____ or _____ will have _____ or _____ care observations completed by _____ by the Director of Education/designee to ensure clinical competency for this standard of practice. Any lack of competency by the team member will be corrected immediately.</p> <p>Residents pending _____ results will have their results reviewed timely to ensure timely ordering of _____. Any results with a delay in treatment will result in a physician notification.</p> <p>The director of education or designee will complete the following educations for nursing team members by _____</p> <p>Licensed nurses will be educated on the signs and symptoms of a _____ and to report laboratory results timely to the provider. Nursing team members will be educated on how to anchor a _____ Certified nursing assistants will be educated on proper _____ procedures.</p> <p>_____ results will be audited to ensure timely review and ordering of an _____ weekly x4 weeks and monthly x12 months</p>	

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F 690	<p>Continued From page 12</p> <p>on her left side, the tubing was pulled tightly. After the care, when asked the use of the anchor, Staff H stated it was to keep the tubing from pulling. Staff G attempted to hook the into the anchor at the junction, in order to secure it, but Staff H told Staff G that was not correct, and put it as it was, leaving the loose and freely moving.</p> <p>During an observation on at 3:43 PM, Staff I, Licensed Practical Nurse (LPN), was unaware of how to utilize the anchor, but agreed the tubing was not secured. When asked if she had assessed the that day, the LPN stated she had and the was cloudy that morning, and agreed it still was. When asked what she should do if the was cloudy, the LPN stated she should notify the physician but had not done so.</p> <p>During an interview on at 9:58 AM, when asked what she would expect a nurse to do if a resident's had cloudy, the Unit Manager stated the nurse should try to flush the, encourage fluids, and call the physician if it persists. The Unit Manager stated she did receive an order for a after the surveyor had asked the nurse about the cloudy the previous afternoon. When asked the process for reviewing the results, the Unit Manager stated the labs are uploaded by the lab into their electronic medical record and the lab will call the facility with any critical results. The Unit Manager explained that both the nurses and physician or nurse practitioner are responsible for reviewing the labs. During a side-by-side review of the record, the Unit Manager was made aware of the of and delay of. The Unit Manager had no reason for</p>	F 690	<p>by the Director of clinical services/designee.</p> <p>anchors will be audited weekly x4 weeks and monthly x12 months by the Director of clinical services/designee.</p> <p>provided to residents with be audited weekly x4 weeks and monthly x12 months by the director of clinical services/designee.</p> <p>All audits will be brought to the QAPI committee monthly for review.</p>	

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F 690	<p>Continued From page 13 the delay.</p> <p>2. Clinical record review revealed Resident #11 was admitted to the facility on _____ with diagnoses that included non-_____. The quarterly Minimum Data Set (MDS) assessment reference date was _____ documented a (_____) score of 06, indicating Resident #11 was severely _____ . This MDS did not record any _____ or behavior concerns. It was documented that she was dependent and required assistance with toileting hygiene, personal hygiene, and toilet transfers, and was frequently _____ of _____, indicating a loss of control.</p> <p>The records included a care plan added to the revised plan dated _____. This care plan documented Resident #11 had related to _____ mobility, with her status potentially varying due to her diagnosis of _____. It also noted that she was frequently _____ of _____ and had the potential for complications secondary to the _____.</p> <p>On _____, a _____ sample was collected, and the _____ results showed a positive _____ (_____), which was reported to the facility by the lab on the same day. Further recollection of _____ was suggested. On _____ the facility was able to straight _____ the resident after several attempts due to her resistance. The results from this _____ collection were reported on _____, confirming the presence of a _____. On _____, a physician order for the _____ 100 mg to be taken orally twice a day for seven days, was initiated.</p>	F 690		

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F 690	Continued From page 14 On _____ at 11:03 AM, _____ care was initiated by Staff B, Certified Nursing Assistant (CNA). Staff B placed a large towel in the bathroom sink, allowed the water to run until the towel was saturated, and then applied soap. After retrieving the wet towel and squeezing some water out, she approached the resident and brusquely instructed her to "open her _____." She then poured water from the towel onto the resident's private area and used wet wipes to clean the _____ area and the top of the pubic bone, but did not provide care to the external structures. Staff B repeated the process, squeezing more water from the towel onto the pubic area and cleaning it with wet wipes. She then instructed the resident to turn, which the resident did without resistance. Staff B squeezed water from the towel onto the resident's _____ and wiped them with the wet towel, then used wet wipes for additional cleaning. Without drying the _____ area, she applied protective _____ cream to the _____ and _____ area, then put on a new adult _____ brief and secured it. The care was completed at 11:09 AM, and Staff B stated, "She was done." Later, at 11:56 AM on _____, the Director of Nursing (DON) and the _____ Control Preventionist were interviewed regarding how the care was provided to resident #11. The surveyor demonstrated the process Staff B had used during the care. The DON and the Control Preventionist agreed that the process was improperly executed.	F 690		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6)	F 757		

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F 757	<p>Continued From page 15</p> <p>§483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-</p> <p>§483.45(d)(1) In excessive dose (including duplicate drug . . .); or</p> <p>§483.45(d)(2) For excessive duration; or</p> <p>§483.45(d)(3) Without adequate monitoring; or</p> <p>§483.45(d)(4) Without adequate indications for its use; or</p> <p>§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or</p> <p>§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure they followed physicians' orders that were recommended by the pharmacy, as evidenced by not discontinuing orders for Resident #48.</p> <p>The findings included:</p> <p>Record review revealed Resident #48 was admitted to the facility on . . . Review of the current Minimum Data Sheet (MDS) assessment dated . . . , documented the resident had a score of 15, on a 0-15 scale indicating no A</p>	F 757	<p>Resident #48 had his . . . and . . . discontinued on . . .</p> <p>Medication recommendations will be audited for . . . of 2024 and the past 90 days to ensure compliance on . . . by the DCS and facility pharmacist. If recommendations were identified as not followed through, they would be implemented at the time of the audit.</p> <p>The clinical services leadership team was educated on following pharmacy</p>	

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F 757	<p>Continued From page 16</p> <p>pharmacy consultation report dated _____ recommended that _____ (medication to promote growth of good _____ in the gut) and _____ (a _____ that is important for normal _____ functioning) be discontinued. On _____ the physician accepted the pharmacy recommendation by signing the consultation. Photographic Evidence Obtained.</p> <p>Review of the current active orders for Resident #48 revealed the resident was still ordered to take _____ and _____.</p> <p>Review of _____'s Medication Administration Record (MAR) for Resident #48 revealed staff had also administered the _____ and _____ to Resident #48 on _____.</p> <p>Further review of the physician orders and MARs from _____ through _____ revealed the supplements had not been discontinued.</p> <p>During an interview on _____ at 4:10 PM, when asked who was responsible for making changes to the resident's orders after the doctor accepts or declines the pharmacy recommendation, the DON stated, the Unit Manager.</p>	F 757	<p>recommendations timely by the Regional Director of Clinical Services on _____.</p> <p>Pharmacy recommendations will be brought to QAPI monthly to review completion and for follow-up by the Director of clinical services/designee.</p>	
F 880 SS=D	<p>Prevention & Control</p> <p>CFR(s): 483.80(a)(1)(2)(4)(e)(f)</p> <p>§483.80 Control</p> <p>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 _____.</p>	F 880		

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F 880	<p>Continued From page 17</p> <p>§483.80(a) prevention and control program.</p> <p>The facility must establish an prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§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;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify 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:</p> <p>(A) The type and duration of the isolation, depending upon the agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable</p>	F 880		

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F 880	<p>Continued From page 18</p> <p>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 policy review, observation, interview, and record review, the facility failed to implement effective control practices by failing to promptly initiate Enhanced Barrier Precautions (EBP) and Transmission-Based Precautions (TBP); and failed to provide appropriate education or ensure competency following facility-acquired () for 4 of 9 sampled residents who should have been on EBP and TBP, involving Residents #129, #80, #31, and #6.</p> <p>The findings included:</p> <p>The policy, titled, "Enhanced Barrier Precautions", with implemented date of , documented it is the policy of this facility to implement enhanced barrier precautions [EBP] for the prevention of transmission of multidrug-resistant</p>	F 880	<p>Appropriate control and/or isolation precautions were initiated for residents #129, #80, #31, and #6 on .</p> <p>Residents on were audited on to ensure that the proper precautions were in place. If precautions were to be found missing they were initiated immediately.</p> <p>Licensed nurses will be educated on transmission based precautions and enhanced barrier precautions by by the Director of Education/Preventionist/designee.</p> <p>orders and precautions will be reviewed by a member of the clinical team</p>	

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F 880	Continued From page 19 organisms (MDROs). Enhanced barrier precautions refer to the use of gown and gloves for the use during high-contact resident care activities for residents known to be colonized or with MDRO acquisition (e.g., residents with _____ or _____ medical devices). The policy documented clear signage will be posted on the door or wall outside of the resident room indicating the type of precautions, required personal protective equipment (PPE), and the high-contact resident care activities that require the use of gown and gloves. Nursing staff may place residents with certain conditions or devices on enhanced barrier precautions empirically while awaiting physician orders. An order for enhanced barrier precautions will be obtained for residents with of the following: (e.g., _____, such as _____, unhealed surgical _____, and _____) and/or _____ medical devices (e.g., central lines, _____ tubes) even if the resident is not known to be _____ or colonized with a MDRO. Examples of targeted and epidemiologically important MDROs include but are not limited to: Enterobacteriales, _____, Acinetobacter baumannii, _____, auris, _____-resistant _____ (_____), ESBL-producing Enterobacteriales, _____-resistant enterococci (VRE), drug-resistant _____ The policy, titled, "transmission-based precautions", dated _____ documented transmission-based precautions are used when the route of transmission is not completely interrupted using standard precautions alone and the _____ may have	F 880	daily to ensure that precautions are implemented timely. orders and precaution signs will be audited weekly x4 weeks then monthly x12 months. The results of these audits will be brought to the QAPI committee monthly for review.	

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F 880	<p>Continued From page 20</p> <p>multiple routes of transmission. Transmission based precautions [TBP] are divided into: contact precautions, droplet precautions and airborne precautions.</p> <p>Contact precautions: wear PPE [Personnel Protective Equipment], gown and gloves for all interactions that may involve contact with the resident or potentially contaminated areas in the resident environment. See nurse sign posting will be on resident rooms alerting health care workers, resident and visitors that they must see the nurse before entering room. The reverse side of the sign will note the type of precaution, method of acceptable and PPE to be utilized.</p> <p>1. Review of the clinical record revealed Resident #80 was admitted to the facility on with a diagnosis that included . The records indicated that on , a sample was collected for , culture, and sensitivity (C&S) testing. The results were reported to the facility on , indicating the presence of extended-spectrum -lactamase (ESBL). On , the resident was prescribed 1 gram of () to be administered , in the afternoon for 7 days to treat bacteremia. The TBP initiation was noted to have been delayed by 4 days. Additionally, a physician's order for contact precautions related to the ESBL was documented on . The care plan, also dated stated that Resident #80 was experiencing bacteremia.</p> <p>2. Review of the clinical record revealed Resident #31 was admitted to the facility on with a diagnosis that included (). Documentation indicated that on</p>	F 880		

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

PRINTED: 05/22/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105592	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2025
NAME OF PROVIDER OR SUPPLIER PALM GARDEN OF VERO BEACH			STREET ADDRESS, CITY, STATE, ZIP CODE 1755 37TH STREET VERO BEACH, FL 32960		
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F 880	<p>Continued From page 21</p> <p> , a sample was collected for culture, and sensitivity testing. The results, reported to the facility on , showed the presence of extended-spectrum -lactamase (ESBL).</p> <p>The initiation of transmission-based precautions (TBP) was delayed by one day. Additionally, a physician's order for contact precautions related to the ESBL was documented on .</p> <p>The care plan, dated , noted that Resident #31 had a () with ESBL and received .</p> <p>3. Review of the clinical record revealed Resident #6 was admitted to the facility on , with a diagnosis that included . On , a sample was collected for culture, and sensitivity testing. The results, reported to the facility on , revealed the presence of extended-spectrum -lactamase (ESBL).</p> <p>On the same day, the resident was prescribed 1 gram of (ATB) to be administered at bedtime for 7 days to treat a . However, initiating enhanced barrier precautions (EBP) was delayed by 2 days. Additionally, a physician's order for EBP related to the and ESBL was documented on .</p> <p>4. The " by Unit Report" from to , documented seven , that included four confirmed as facility-acquired for Residents #129, #80, #31, and #6.</p> <p>On at 12:07 PM, an interview was conducted with the Control Preventionist () and the Director of Nursing (DON). When asked about the Transmission-Based Precautions</p>	F 880			

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F 880	<p>Continued From page 22</p> <p>(TBP) and Enhanced Barrier Precautions (EBP) that should have been implemented for Residents #129, # 80, 31, and #6, the acknowledged that these precautions were initiated late. The indicated that the nurses did not begin these precautions. She revealed the facility had identified the issue on Monday, which coincided with the arrival of the survey team at the facility.</p> <p>The stated the facility had been experiencing increasing facility-acquired . The surveyor inquired about the actions taken in response and whether education or competency assessments had been provided to the Certified Nursing Assistants. The surveyor requested documented evidence of such education or competency training. The stated she walks around and speaks with the staff regarding control, reminding them to maintain good care and practice proper hygiene while emphasizing caution. Notably, the pointed out that she typically does not require staff to sign in-service documentation, indicating a lack of documented competency assessments or in-service training related to .</p> <p>5. Record review revealed Resident #129 was admitted to the facility on with Diagnosis that included, in part:</p> <p>(), unspecified injury at C3 cord, (), dependence on wheelchair and ().</p> <p>On , the facility received a analysis results for Resident #129. The results indicated the resident had ESBL (Extended Spectrum Lactamases) in their . The diagnosis of ESBL makes</p>	F 880		

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F 880	<p>Continued From page 23</p> <p>harder to treat with . . . ESBL producing can spread from person to person. It can be contacted by simply touching an person or touching soiled objects that have not been cleaned thoroughly. By review of the facility policy, a resident who has the diagnosis of ESBL should be on contact precautions. When a resident has any type of precautions in the facility, a sign is to be posted on the door of the resident's room to indicate which type of precautions are to be followed.</p> <p>On . . . at 9:00 AM, a tour was conducted of the facility. Resident #129's door was observed, and the door did not have any posting for contact precautions.</p> <p>During an interview, on . . . at 11:02 AM, the . . . Preventionist stated that she had not completed rounds from the previous weekend to determine additional precautions for residents.</p>	F 880			