Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35960864	A. BUILDING: _____ B. WING _____	C 02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF ORANGE PARK	2145 KINGSLEY AVE ORANGE PARK, FL 32073

(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
N 000	INITIAL COMMENTS A Re-licensure survey was conducted in conjunction with a Complaint investigation (complaint #2025001109) at Life Care Center of Orange Park from February 3, 2025 through February 6, 2025. The complaint could not be substantiated. The provider had deficiencies at the time of the visit resulting from the Re-licensure survey. .	N 000		
N 054	59A-4.107(5), FAC Follow Physician Orders All physician orders must be followed as prescribed, and if not followed, the reason must be recorded on the resident's medical record during that shift. This Statute or Rule is not met as evidenced by: Based on observations, resident and staff interviews, and a review of resident records, the facility failed to ensure physicians' orders were followed as prescribed by failing to 1) Ensure residents with pressure ulcers received necessary treatment and services for one (Resident #144) of three residents reviewed for pressure ulcers who was not receiving treatments as per the physician's orders, and 2) Ensure that residents requiring respiratory care received such care as prescribed for one (Resident #226) of two residents reviewed for respiratory care, from a total of 21 residents receiving oxygen therapy, who was not receiving oxygen at the flow rate the physician ordered.	N 054	The center provides the following Plan of Correction (POC) without admitting or denying the validity or existence of alleged deficiencies. The POC is prepared and/or executed solely because it is required by the provisions of federal and state law. The facility reserves all rights to contest survey findings through informal dispute resolutions, formal appeal proceedings, or any administrative or legal proceedings. On 2/3/2025, wound care treatment/ services were immediately provided to resident #114, according to physician orders. The provider for resident #114 was notified of the missed dressing change/ treatment identified on 2/3/2025. In	2/28/25

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N 054	Continued From page 1 The findings include: 1. On 2/03/2025 at 12:17 p.m., Resident #114 was seated in her wheelchair with both feet (red socks in place) dangling down towards the floor. A white gauze bandage was observed protruding from her sock around her right ankle area. When asked what happened, Resident #114 reported she had a sore from a tight shoe strap that cut into her skin a couple of months ago. She reported no pain, stating staff came in to change her bandage every few days. On 2/04/2025 at 10:22 a.m., Resident #114 was seated in her wheelchair with both feet dangling down towards the floor. A red sock covered her left foot, and her right foot was partially covered by a sock. A white gauze bandage was wrapped around the middle of her right foot and up over her ankle. In black writing, "1/31" was documented on the bandage. (photographic evidence obtained) Resident #114 could not recall when staff last came to change her bandage, but stated she informed the nurse last night of foot pain and throbbing. A review of the resident's medical record revealed she was admitted on 02/25/2023 with diagnoses including urinary tract infection, Alzheimer's disease, and peripheral vascular disease. A review of the quarterly Minimum Data Set (MDS) assessment, dated 01/15/2025, revealed that Resident #114 had a Brief Interview for Mental Status (BIMS) score of 14 out of 15	N 054	addition, Unit Care Coordinator adjusted settings to oxygen delivery devices for resident #226, to reflect physician□s orders. DON observed oxygen delivery devices for resident #226 to ensure following of physician orders pertaining to oxygen therapy. On 2/3/2025, the Director of Nursing/ Designee completed an audit/ review of other residents requiring dressing changes to ensure residents receive care consistent with professional standards of practice, to prevent pressure ulcers and to not develop pressure ulcers unless the individuals condition demonstrates that they were unavoidable. No additional concerns were identified. In addition, A facility wide audit was completed by the DON/ Designee on 2/4/25, to ensure no other residents affected. None were identified. Physician orders for oxygen were reviewed and delivery devices were observed to ensure accuracy of oxygen administration. On 2/10/25 the Director of Nursing/ Designee initiated in-servicing with re-education for licensed nurses reviewing facility policies and procedures for Skin Integrity and Pressure Ulcer Prevention and Management. In addition, In-services with re-education for licensed nurses pertaining to the facility policy and procedures for Oxygen Administration, Safety, and Storage were initiated by the DON/ Designee on 2/10/25. Newly hired licensed nurses will have the policy and procedures reviewed during orientation and the facility expectations explained. The Director of Nursing/ designee will conduct ongoing routine audits of	

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N 054	Continued From page 2 possible points, indicating intact cognition. She was documented with a stage 3 pressure ulcer and was receiving pressure ulcer/injury treatment and care. (photographic evidence obtained) A review of the resident's active, person-centered Care Plan revealed that she had a pressure injury to her right heel. Interventions included administration of treatments as ordered. (photographic evidence obtained) Active physician's orders revealed: 01/08/2025 - "wound care consult, right heel". 01/10/2025 - wound care orders indicated: "cleanse with normal saline, pat dry and skin prep peri wound, apply honey gel/collagen powder/calcium alginate to wound bed, cover with ABD pad and secure with rolled gauze every 2 days and as needed with start date of 1/11/2025. No end date was indicated. (photographic evidence obtained) A review of the wound provider's progress note dated 01/30/2025, revealed: "Stage 3 pressure wound of the right heel full thickness, exudate moderate serous, 20% slough, 80% granulated tissue, primary dressing leptospermum honey apply every two days for 11 days; Collagen powder apply every two days for 11 days; Alginate calcium apply every two days for 11 days. Secondary dressing ABD pad (abdominal dressing) apply every two days for 11 days; Gauze roll apply every 2 days for 11 days. Peri wound treatment skin prep applied every two days for 11 days."	N 054	residents requiring dressing changes, bi-weekly times 4, then monthly times 3 followed by as needed to ensure compliance with dressing change procedures to provide services necessary to prevent/ heal pressure ulcers. These findings will be reviewed in Quality Assurance Performance Improvement Meeting monthly times 3 months and then as needed, if concerns arise. In addition, The Director of Nursing/ designee will conduct oxygen administration observations with focus on following physician orders, bi-weekly times 4, then monthly times 3 followed by as needed to ensure compliance with following physician orders, pertaining to respiratory care. These findings will be reviewed in Quality Assurance Performance Improvement Meeting monthly times 3 months and then as needed, if concerns arise.	

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N 054	Continued From page 3 A review of Resident #14's February 2025 treatment administration record (eTAR) revealed: "R Heel: Cleanse with normal saline, pat dry, skin prep peri wound, apply honey gel/collagen powder/ calcium alginate to wound bed, cover with ABD pad and secure with rolled gauze every 2 days and as needed" had been signed off as "Administered" on 2/2/2025 and 2/4/2025, despite the observation made with the wound bandage dated "1/31" on 02/04/2025. (photographic evidence obtained) On 02/06/2025 at 8:52 a.m., an interview with Certified Nursing Assistant (CNA) G revealed she had been working for the facility for two years and had been assigned to work with Resident #114. She confirmed a wound to the right heel that was covered. She could not recall how often the bandage was changed but stated if she saw an old, dated bandage she would report it to her unit manager. She denied seeing or reporting old, dated wound bandages for Resident #114 to the unit manager. She confirmed working on 2/4/2025 with Resident #114, where she got her up from bed around 9:30 a.m., placed her socks on her feet, and sat her in her wheelchair. On 02/06/2025 at 8:52 a.m., an interview with Licensed Practical Nurse (LPN) H revealed he had been working at the facility for five years, passing medication and assisting with wound care when the wound care nurse was not scheduled. He confirmed being assigned to Resident #114 and confirmed working with her on 2/2/2025. He reported offering to administer her wound care treatment, but being told by the resident to come back later. He went in another time but he was postponed again. When he	N 054		

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N 054	Continued From page 4 came back a third time, she was in bed and his shift ended at 7:30 p.m., so he reported never completing the treatment. He further stated he never went back to unmark the treatment was administered; he never notified oncoming staff that the wound treatment wasn't provided, and he never followed up on his next scheduled shift the following day. He agreed that a missed wound treatment was dangerous and reported, "Infection could happen if proper wound care is not provided." On 02/06/2025 at 1:37 p.m., an interview with the Assistant Director of Nursing confirmed the expectation when administering medications and physician ordered treatments was to follow the physician's orders. Nurses signed off after the care/medication had been provided. If a resident refused, nursing should document the refusal, and if administered/treated late, nursing should document that the treatment was completed late. A review of the facility's policy and procedure titled Skin Integrity and Pressure Ulcer/Injury Prevention and Management" (revised 07/09/2024), ADL Care and Services", revealed: Provide associates and licensed nurses with procedures to manage skin integrity, prevent pressure ulcer/injury, complete wound assessment/documentation, and provide treatment and care of skin and wounds utilizing professional standards of NPIAP (National Pressure Injury Advisory Panel) and WOCN (Wound, Ostomy, Continent Nurses Society). The policy interpretation and implementation indicated: 4. Measures to maintain and improve the resident's tissue tolerance to pressure are implemented in the plan of care. 7. When skin	N 054		

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N 054	Continued From page 5 breakdown occurs, it requires attention and change in the plan of care may be indicated to treat the resident. (photocopy obtained) 2. On 02/04/25 at 9:59 AM, Resident #226 was observed resting in bed with her eyes closed. She was wearing a nasal cannula attached to an oxygen concentrator and was receiving oxygen at a flow rate of 4 liters per minute (4L/min). (photographic evidence obtained) On 02/04/25 at 1:29 PM, Resident #226 was observed resting in her room. She did not know the appropriate setting for her oxygen flow rate and stated she did not adjust it herself. On 02/05/25 at 10:43 AM, Resident #226's oxygen flow rate was set at 3L/min. (photographic evidence obtained) A review of Resident #226's medical record revealed an admission date of 12/04/24 and diagnoses including altered mental status, atherosclerotic heart disease (a condition where plaque builds up in the arteries that supply blood to the heart), cardiomegaly (enlarged heart with difficulty pumping blood), hypertensive heart disease (a condition that develops when chronic high blood pressure damages the heart muscle), conjestive heart failure (CHF - a condition where the heart muscle is weakened and cannot pump blood effectively), and metabolic encephalopathy (a condition where the brain does not function properly due to an underlying metabolic imbalance).	N 054		

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N 054	Continued From page 6 A review of Resident #226's physician's orders revealed: Oxygen at 2 liters/minute continuously per nasal cannula, every shift. Order was active and written on 01/15/25 at 7:00 PM. Change oxygen tubing and nebulizer circuit every night shift every Sunday. Order active and written on 12/08/24 at 7:00 PM. Clean oxygen concentrator filter with soap and water weekly every Sunday. Order active and written on 12/08/24 at 7:00 PM. Check oxygen saturation rates every shift. Order was active and written on 12/04/24 at 7:00 PM. A review of the 01/03/25 Minimum Data Set (MDS) assessment revealed a Brief Interview for Mental Status (BIMS) score of 03 out of 15 possible points, indicating severe cognitive impairment. Functional abilities and goals revealed the following: Substantial/maximum assistance required for roll left and right, sit to lying, lying to sitting on side of bed, and dependent for sit-to-stand, chair/bed-to-chair transfer and toilet transfers. A review of the care plan (initiated on 12/05/24) revealed the following focus area: The resident has coronary artery disease (CAD) related to atherosclerosis, hypertension and hyperlipidemia. Goal: The resident will be free from signs or symptoms of complications of cardiac problems through the review date. Interventions: Oxygen settings: O2 via Nasal cannula at 2 liters continuous. Change out 02 tubing, nasal cannula weekly and as needed.	N 054		

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N 054	Continued From page 7 A review of the February 2025 medication administration record (MAR) and treatment administration record (TAR) revealed that oxygen was administered per physician's order and signed off by facility staff on each shift. On 02/06/25 at 11:27 AM, an interview was conducted with Certified Nursing Assistant (CNA) J, who stated she had been employed by the facility for five years. She explained that as a CNA, she was not permitted to adjust a resident's oxygen flow rate. She observed the flow rate and whether or not the tank was empty. If she did not know what a resident's flow rate should be or noticed that an oxygen tank was empty, she would consult with the nurse. On 02/06/25 at 11:41 AM, an interview was conducted with Licensed Practical Nurse (LPN) K, who stated she had been employed by the facility for seven months. She explained the process for caring for residents receiving oxygen (O2) therapy. Some residents received an O2 order for "as needed (prn)" oxygen, and others received an O2 order for continuous oxygen. Residents' O2 orders should be discussed between the oncoming and outgoing nurse during walking rounds at shift change. During shift change, LPN K stated she would look around a resident's room and if she saw the resident was on O2, she would ask the outgoing nurse what the resident's flow rate was. She would then use a piece of paper and write the resident's name, orders, special medical condition, appointments, or any concerns noted by the outgoing nurse. Residents receiving oxygen should always have their head raised while receiving oxygen. LPN K would also use a pulse oximeter to obtain oxygen	N 054		

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N 054	Continued From page 8 saturation levels. If a resident's oxygen level was low, she would check the oxygen cannula and tubing to ensure they weren't damaged. She would also check the water tank to ensure that the water was bubbling. She made a practice of checking oxygen flow rates at the beginning of her shift and anytime she went into a resident's room, which was "usually at least three times" during her shift. LPN K explained that she was familiar with Resident #226 as she checked the electronic medical record for the oxygen order, reporting that the current order for oxygen was 2L/min. The order was written on 01/15/25. She stated when she started her shift this morning, she observed Resident #226's oxygen flow rate was set at 2L/min. A review of the facility's policy for Oxygen Administration (issued 12/03/18, reviewed 09/24/24, revised 10/11/24), revealed: Respiratory care . . . The facility must ensure that a resident who needs respiratory care is provided such care, consistent with the comprehensive person-centered care plan . . . Procedure: 1. Oxygen order should be written for specified liter flow required by the resident. Class III	N 054		