STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105466	A. BUILDING _____ B. WING _____	**08/27/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE OF PALM BEACH	**4405 LAKEWOOD ROAD LAKE WORTH, FL 33461**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0684 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide care for a resident with a surgical wound and to follow physician's orders for wound dressing changes and pedal pulse checks, resulting in the need for urgent surgical debridement and subsequent skin grafts. This affected 1 of 3 sampled residents reviewed for surgical wounds (Resident #1). The findings included: During an interview on 08/27/20 at 9:50 AM, a family member of Resident #1 stated that Resident #1 had been admitted to the facility on [DATE]. Resident #1 had undergone vascular bypass surgery on his right leg and needed surgical wound care and physical therapy. The family member stated that Resident #1 had a follow up appointment on 06/04/20 with the vascular surgeon and at that time, the surgical incision was intact and look good (photographic evidence provided). The family member stated that Resident #1 had a second follow up appointment with the vascular surgeon on 06/11/20. The family member stated that at this visit, the surgical incision had dehiscence (a partial or total separation of previously approximated wound edges) and the underling tissue was black and necrotic. Necrotic tissue is dead or devitalized tissue (photographic evidence obtained). The vascular surgeon informed the family member that the tissue cannot be salvaged and must be removed urgently. The family member stated that Resident #1 had to have a surgical debridement (the removal of dead necrotic or infected skin tissue) on 06/12/20 and lost a portion of his calf muscle and has subsequently had to have multiple skin grafts to cover the wound. The family member stated that she could not believe the staff at the facility had not communicated anything to the family about Resident #1's wound or called the vascular surgeons office. The family member stated that the wound was to have a dressing change every day and that she spoke to the nurses every other day on the phone to see how Resident #1 was doing and no one ever mentioned anything about the wound. Clinical record review revealed that Resident #1 had been admitted to the facility on [DATE]. Resident #1's admitting [DIAGNOSES REDACTED]. [DIAGNOSES REDACTED] is a type of [MEDICAL CONDITION] that causes your bone marrow to make too many red blood cells, excess cells thicken your blood slowing its flow, which may cause serious problems, such as blood clots. Resident #1 is documented as having mild cognitive impairment. Resident #1 had been hosptalized on [DATE] with an occlusion of his right superficial femoral artery and underwent bypass from below the knee popliteal to peroneal artery. Resident #1 had a surgical incision from his right groin to his knee (upper), and a second incision from his right knee to his ankle (lower). Resident #1 had a physician's orders dated 05/27/20: Head to toe skin checks weekly on Monday day shifts. Resident #1 had a physician's orders dated 05/27/20: Monitor surgical site to right lower extremities for signs and symptoms of infection every shift. Resident #1 had a physician's orders dated 05/28/20: Right leg upper/lower extremities coat incision and staples with [MEDICATION NAME] then cover with 4x4 gauze and wrap with ace wrap daily until follow up with surgeon. Day shift. Resident #1 had a physician's orders dated 06/08/20: Right leg upper/lower extremities coat incision and staples with [MEDICATION NAME] then cover with 4x4 gauze and wrap with ace wrap daily until follow up with surgeon. Day shift. Review of Resident #1's hospital discharge paper worked scanned into the facility record dated 05/27/20 revealed , the Discharge Plan from the vascular surgeon, follow up doppler ultrasound, check pedal pulses every 4 hours, and right leg upper/lower extremities coat incision and staples with [MEDICATION NAME] then cover with 4x4 gauze and wrap with ace wrap daily. The resident was not on antibiotics. Review of Resident #1's History and Physical dated 06/01/20 revealed that Staff D, a Nurse Practitioner, documented that Resident #1's Treatment Plan was to follow the vascular surgeon's recommendations to check pedal pulse every shift. Further review of the record revealed that Resident #1's Treatment Plan was updated on 06/03/20, 06/06/20, 06/08/20 and 06/10/20, and all updated plans documented to check pedal pulses every shift. The resident had no documented fever while at the facility. The resident's care plan included only a baseline care plan for Wound care as ordered. Further review of Resident #1's record revealed that there was no order for Resident #1 to have his pedal pulses checked. There was no evidence the nurses checked the pedal pulse every 4 hours as documented on the discharge plan by the vascular surgeon. Review of Resident #1's Treatment Administration Record (TAR) revealed no gaps in documentation for the monitoring of the surgical site for signs and symptoms of infection. The TAR revealed no gaps in documentation for the right leg upper/lower extremities coat incision and staples with [MEDICATION NAME] then cover with 4x4 gauze and wrap with ace wrap daily until follow up with surgeon. Review of Resident #1's hospital record revealed an admission assessment dated [DATE] documenting right lower extremity wound necrosis and dehiscence. Surgical debridement of necrotic tissue and eschar, decreased sensation at digits, wound vac, receiving [MEDICATION NAME], and a wound culture gram positive cocci. Review of the facility provided policy on 08/27/20, Physician Orders at a glance, last revised on 11/06/19; Physician/Medical Practitioners orders given via telephone or verbal: The Nurse receiving the order is responsible for complete order documentation. During an interview on 08/27/20 at 1:00 PM Staff A, a Registered Nurse and the Wound Care Nurse, stated that she had assessed and treated Resident #1's on 06/08/20. Review of Staff A's Observation Note of 06/08/20 revealed 'Resident was in bed resting comfortably, denied any pain prior to treatment. Dressing change to right lower medial leg has 28 staples intact with small opening within staples 1.5 cm x 0.5cm x 0.5cm, edges redness, peri-wound with large purple bruising, moderate amount of sero-sanguineous drainage with no warmth or odor noted. Coated with [MEDICATION NAME] covered with dry dressing secured with kerlix/ace wrap. No pain noted. Seen by Nurse Practitioner today and will follow up with Surgeon on 6/11/2020.' Staff A stated that during the time period Resident #1 was in the facility, she was not working exclusively as the wound care nurse, and she had been assigned to work in the facilities COVID Unit. Staff A stated that she was doing weekly wound assessments, but the Unit Nurses were completing the ordered treatments. A side by side review of Resident #1's TAR for 06/08/20 revealed that Staff A had not documented on the TAR that she had done the ordered treatment. The TAR on 06/08/20 for the ordered 'right leg upper/lower extremities coat incision and staples with [MEDICATION NAME] then cover with 4x4 gauze and wrap with ace wrap daily' was signed off by Staff B, a registered nurse. Staff A stated that Staff B was the resident's unit nurse on 06/08/20. Staff A was asked why the unit nurse would sign off on a treatment that she (Staff B) had completed. Staff A stated that the unit nurses often sign off on the TAR for wound care. Staff A was asked about Resident #1 having his pedal pulses assessed every shift. Staff A stated that Resident #1 should have had his pedal pules checked. Staff A stated that the Nurse Practitioners and Physicians are to communicate with the Unit nurses regarding their orders, and the nurses put the orders in the computer. During an interview at 2:30 PM on 08/27/20, Staff C, a registered nurse, was asked to review Resident #1's TAR for 06/09/20 and 06/11/20. Staff C stated that she had been assigned to Resident #1 and had signed off on the TAR for the ordered 'Right leg upper/lower extremities coat incision and staples with [MEDICATION NAME] then cover with 4x4 gauze and wrap with ace wrap daily'. Staff C stated that she did not recall any issues with Resident #1's surgical incision on 06/09/20. Staff C stated that on 06/11/20, she did sign off for the treatment but did not change the dressing on 06/11/20 because the resident had gone to a follow up appointment at the vascular surgeon and when he returned he had a fresh dressing on his leg. Staff C was asked about

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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 0684 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) Resident #1 having his pedal pulses checked. Staff C stated that she recalled Resident #1 had a doppler of his right leg done on 06/02/20 but was unaware of the results. Staff C stated that she was not aware that the resident was to have his pedal pulse checked every shift. In a side by side review of Resident #1's 06/01/20 History and Physical, and review of treatment plan, Staff C stated that checking the pedal pulses should have been an order. Staff C stated that the Nurse Practitioners communicate to the unit staff what they want for orders. Staff C did not recall any Nurse Practitioners communicating to her regarding Resident #1 needing pedal pulses checked. During an interview at 8:20 AM on 08/28/20 Staff D, a Nurse Practitioner, stated that he could not recall the last time he has seen Resident #1's surgical wound. Staff D stated that he relied on the nurses to keep him informed if there were concerns about a resident. Staff D stated that he had received a request from Staff A regarding Resident #1's surgical incision on 06/08/20. Staff D stated that when he assessed the resident (06/08/20), the dressing was intact, and he did feel a pedal pulse. Staff D stated that he always discusses and reviews residents' condition and plans with the nurses. When asked if he had ordered Resident #1 to have his pedal pulses checked every shift, Staff D stated absolutely and that was something he reviewed with the nurses every time he saw the resident. Staff D stated that he currently does not enter orders into the facility's Electronic Medical Record (EMR), the facility staff enter orders. Staff D stated that of course a resident that had just had vascular surgery would have to have his pedal pulses checked. Staff D could not recall what Unit nurses he had reviewed Resident #1's care with. During an interview at 6:30 PM on 08/28/20, Staff B, a Registered Nurse, stated that she had been assigned to Resident #1 on 06/08/20 and 06/10/20. Staff B reviewed the TAR for 06/08/10 and stated that she had signed off on Resident #1's ordered 'right leg upper/lower extremities coat incision and staples with [MEDICATION NAME] then cover with 4x4 gauze and wrap with ace wrap daily', but she had not actually done the treatment but the wound care nurse, Staff A, had done it. Staff B stated that when the wound care nurse does the dressing change, the unit nurse usually sign off on the TAR. Staff B stated that she documented that the dressing was clean and intact on 06/08/20, not that she had done it. Staff B was asked to review the TAR for 06/10/20. Staff B stated that it is the same as 06/08/20, I documented that the dressing was clean and intact because the wound care nurse would have done it. Staff B was asked if she had communicated with the wound care nurse about Resident #1's wound on 06/10/20. Staff B stated that she could not recall. Staff B was asked if she had any direct observation of Resident #1's lower right surgical incision on 06/08/20 or 06/10/20, Staff B stated that she was not sure, I don't think I did, I was assuming the dressing had been changed. Staff B was asked about Resident #1 having his pedal pulses checked. Staff B stated that she was not aware that the resident was to have his pedal pulse checked every shift. In review of Resident #1's 06/01/20 History and Physical and review of Treatment Plan, Staff B stated that checking the pedal pulses should have been an order. Staff B stated that the Nurse Practitioners communicate to the unit staff and a staff nurse puts the orders in the EMR. Staff B did not recall any Nurse Practitioners communicating to her regarding Resident #1 needing pedal pulses checked. Further review of the clinical record revealed no evidence or documentation of wound or dressing assessment when the resident returned from the surgeon's visit on 06/11/20 to when the resident was discharged to the hospital on the morning of 06/12/20 for surgical intervention. Review of the staffing assignments for 06/08 through 06/11/20 revealed the wound care nurse was either not working these days or not on the unit the resident was on but was an assigned unit nurse on another unit of the facility. The staff nurses had assumed the wound care nurse had completed the dressing changes for the resident. During an interview at 4:30 PM on 08/27/20, the Administrator stated that currently the Nurse Practitioners are not entering orders into the EMR, the facility staff are entering the orders. The Administrator stated that there is planned training for the Nurse Practitioners and the Doctors to enter their orders into the EMR.