STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105917	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CONSULATE HEALTH CARE OF JACKSONVILLE	**4101 SOUTHPOINT DRIVE EAST JACKSONVILLE, FL 32216**

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 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and review of the facility resident rights; the facility failed to 1) ensure that it provided the resident right to privacy after staff knocked on the door of the resident and staff did not allow the cognitively intact resident to invite staff into the room for 1 (Resident #78); and 2) facility staff failed to ensure dignity during dining for 1 (Resident #10) resident observed out of 37 sampled residents. The findings include: An interview was conducted on 03/03/2020 at 09:32 AM with Resident #78 about concerns related to staff on a prior evening. As the Surveyor entered the single bedroom occupied by Resident #78, the resident stated to the Surveyor, close the door. Resident #78 said he wanted to talk privately. On 03/03/2020 at 09:36 AM during the interview conducted with Resident #78 Employee B, Physician knocked on the resident's door, then walked in. Employee B, Physician was greeted by the Surveyor, introduced herself as the doctor, and proceeded to comment to Resident #78 about care. When Employee B, Physician completed the encounter with Resident #78, this Surveyor conducted an interview with Employee B, Physician on 03/03/2020 at 9:38 AM. Employee B, Physician provided that she did not wait after knocking to be invited in by Resident #78. Employee B, Physician commented, I guess I am supposed to wait until I hear from Resident #78 after knocking. The interview continued with Resident #78 on 03/03/2020 at 09:42 AM. Employee C, CNA knocked at the door for Resident #78 and walked into the room before Resident #78 could respond to the knock. Resident #78 was sharing concerns related to a staff member who cared for him. An interview was conducted with Employee C, CNA on 03/03/2020 at 9:42 AM. Employee C, CNA confirmed that he worked in central supply and he delivered gloves at that time. Employee C, CNA said that he was supposed to knock and wait to be invited into the room, if he did not hear anyone, he would knock again. Employee C, CNA confirmed that he just walked in to deliver gloves. He apologized and walked out after he placed the gloves on the counter. On 03/03/2020 at 09:45 AM, Resident #78 was interviewed and he stated he wanted the staff to knock and wait to be invited in; especially when the door was closed. He stated, they do not give you time, they just walk in. An interview was conducted with Employee L, CNA on 03/04/2020 at 11:25 AM. She stated that she was supposed to knock on the door when working with residents, and wait for the resident to invite her in. An interview was conducted with the Director of Nursing (DON) on 03/05/20 10:45 AM; She confirmed that staff should knock before entering a resident room. The DON stated that it was best practice to knock, open the door and wait until the resident responded. Staff were required to knock, say good morning and introduce themselves to the Resident. An interview was conducted with the DON on 03/05/2020 at 10:45 AM about privacy for residents. The DON presented the facility Nursing Home Resident Rights section 400.022 Florida Statutes which documented that each resident shall have the right to: Privacy in treatment and in caring for personal needs and Be treated courteously, fairly, and with the fullest measure of dignity. The DON stated that it was best practice to knock on the door of a resident's room and allow the resident to invite staff in. A review of the minimum data set for Resident #78 was conducted and documented that Resident #78 Brief Interview of Mental Status score (BIMS) was 15. This indicated that Resident #78 was cognitively intact. . 2) Record review for Resident #10 revealed that she was admitted into the facility on [DATE]. Her last readmission was 12/25/2019. Her [DIAGNOSES REDACTED]. Per the quarterly Minimum Data Set assessment on 11/25/2019 Resident #10 had a brief interview for memory status score of 0/15 and required extensive assistance of one with eating. On 3/03/2020 at 11:52am, Resident #10 was observed in her room with the door ajar eating unassisted. From the hall leading to the door of the room, food was observed on the residents face, clothes, inside of her nostrils and smeared on the room floor. On 3/04/2020 at 12:31pm, Resident #10 was observed in her room with the door ajar unassisted. From the hall leading to the door of the room, food was observed on the residents face, hands and clothing. On 3/05/20 at 12:26pm, Resident #10 was observed in her room with the door ajar eating unassisted. From the hall leading to the door of the room, food was observed on the residents face, hands and clothing. On 3/05/2020 at 03:04pm Resident #10 was observed in her room with the door ajar ambulating in throughout the room. The lunch tray was observed on the table in the room. From the hall leading to the door of the room, food was observed on the resident's face, hands, clothes, tray table and smeared on the floor of the room. During an interview on 3/05/2020 at 12:28pm with Employee N, a Registered Nurse and Minimum Data Set Coordinator, she explained to the Surveyor that residents who require extensive assistance with eating are to be accompanied by a Certified Nursing Assistant (CNA) when eating in their rooms. During an interview on 3/05/2020 at 1:53pm with Employee H, a Licensed Practical Nurse, she confirmed that the resident usually eats in her room. She also stated that a CNA should be monitoring resident eating in their rooms who required extensive assistance with eating. Additionally, she stated that Resident #10 should be closely monitored, that she always has a lot of drool and food on her and on her clothes and that the CNAs should be going by to make sure she's clean. .
F 0583 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Keep residents' personal and medical records private and confidential.** Based on observation, interview and record review, the facility failed to provide privacy during personal care for 1 of 1 resident that was reviewed in a sample of 37 residents (Resident #8). The findings include: On 03/03/20 at 11:12 AM, during an interview, Resident #8 stated staff often will provide care to him and his room mate with blinds to the parking lot open. On 03/04/20 at 09:30 AM During observation, Employee G was observed performing bed bath and peri care for Resident #8 room mate with the door to the hallway open, the privacy curtains between A bed and B bed open and the window blinds to the parking lot open. Resident #8 stated this happens every day when Employee G is working. On 03/04/20 at 9:37 AM, Employee A and Employee D were informed of Employee G providing pericare and bedbath to resident with door to hallway open, privacy curtain between A bed and B beds open, and window blinds open to the parking lot. On 03/05/20 at 02:47 PM, Interview with Employee A where she stated there was immediate education for Employee G and one and one counseling regarding privacy during activities of daily living (ADL) care. On 03/05/20 at 03:15 PM, During an interview with the Administrator and asked for facility policy and procedures on providing privacy when performing ADL care. She stated her expectations for employees providing ADL care is the doors will be closed, window blinds closed and privacy curtains pulled between both beds. .
F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews and facility policy and procedure review, the facility failed to ensure a clean

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

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F 0584 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) environment for 3 (Residents #44, #72 and #4) out of 10 residents who received enteral ([DEVICE]) feedings out of a total of 37 sampled residents. Failure to maintain a clean environment puts the residents at risk for infections that may negatively affect their medical condition. The findings include: On 03/02/2020 at 9:40 AM room [ROOM NUMBER]B (Resident #72's room) was observed to have enteral food product splattered on the floor, wall behind the bed, nightstand, [DEVICE] pump and pole. On 03/03/2020 at 10:10 AM room [ROOM NUMBER]A (Resident #44's room) was observed to have enteral food product splattered on the floor, frame of the bed, nightstand, [DEVICE] pump and pole and the door to the room next to the garbage can where the enteral food product container and tubing had been discarded. There was debris on the floor under the bed. A purple plastic cup and the cap from the [DEVICE] were observed (Photographic evidence obtained). On 03/03/2020 at 1:05 PM room [ROOM NUMBER]B (Resident #4's room) was observed to have enteral food product splattered on the floor, frame of the bed, nightstand, [DEVICE] pump and pole and the oxygen concentrator next to the bed. On 03/05/20 at 09:55 AM room [ROOM NUMBER]A was observed to have enteral food product splattered on the floor, frame of the bed, nightstand, [DEVICE] pump and pole and the door to the room next to the garbage can where the enteral food product container and tubing had been discarded. There was debris on the floor under the bed. A purple plastic cup and the cap from the [DEVICE] were observed (Photographic evidence obtained). On 03/05/2020 at 11:14 AM room [ROOM NUMBER]B was observed to have was observed to have enteral food product splattered on the floor, wall behind the bed, nightstand, dresser, [DEVICE] pump and pole (Photographic evidence obtained). On 03/05/2020 at 11:27 AM room [ROOM NUMBER]B) was observed to have enteral food product splattered on the floor, frame of the bed, wall behind the bed, nightstand, [DEVICE] pump and pole and the oxygen concentrator next to the bed (Photographic evidence obtained). During an interview with Employee J, Housekeeping, on 03/05/20 at 11:13 AM, she stated her permanent assignment is on the 300 hallway. She confirmed she is a full time employee. She was observed on 03/02/2020, 03/03/2020, 03/04/2020 and 03/05/2020 working on the 300 hallway. She was shown the debris under Resident #44's bed. She stated I'm not gonna lie. I didn't move the chair out of the way and sweep under the bed over there. She stated that she does sweep the floors in the rooms. She moved the oxygen concentrator away from the bed and a brown liquid was puddled on the floor (Photographic evidence obtained). She stated she would have wiped up the food product on the floor, nightstand, oxygen concentrator, IV pole and bed frame if she had seen it. She stated the nurses usually wipe up the food product if they spill it. During an interview with the Director of Nursing, RN, 03/05/2020 at 11:15 AM, she observed Resident #44's room and stated that whatever staff member sees the problem should clean it up. The nurse should clean up the enteral food product if they spill it when it happens. During an interview with Employee K, Housekeeping Director, on 03/05/2020 at 12:50 PM, she stated that the housekeepers should be cleaning up the enteral product if the nurses do not do it when they are starting a feeding or stopping a feeding. On 03/05/2020 at 2:10 PM the ADON produced an in-service for the nursing staff on documentation in the clinical record. Review of the form revealed the training was entitled Nurses Meeting 02/27/2020 and the sign in sheet was dated 02/27/2020. The topics covered included: Tube feedings - assure that pole is clean. Review of the facility policy and procedure entitled 5-Step Daily Room Cleaning, revised 10/25/2016 revealed it read: Purpose: To teach Environmental Services employees the proper cleaning method to sanitize a patient room or any area in a healthcare facility. 2. Horizontal Surfaces-disinfected. Using a solution of properly diluted germicide, sanitize all horizontal surfaces (allowing for appropriate solution dwell time). Tabletops, headboards, windowsills, chairs-should all be done. 3. Spot Clean Walls. Vertical surfaces are not completely wiped down daily - but must be spot-cleaned daily. Walls -especially by trash cans, light switches and door handles - will need special attention. 4. The entire floor must be dust mopped-especially behind dressers and beds. Move all furniture to dust mop. 5. The most important area of a patient's room to disinfect is the floor. This is where most air-borne bacteria will settle and so it needs to be sanitized daily. As with dust mopping, start in the far corner of the room, move all furniture necessary and run the mop along the edges first. .
F 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that included measurable objectives and timeframe's to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 2 of 37 residents sampled, Resident #32 and Resident #58. The findings include: A record review for Resident #32 revealed that she was admitted into the facility on [DATE]. Her [DIAGNOSES REDACTED].#32 included: [MEDICATION NAME] 100mg by mouth twice a day; [MEDICATION NAME] 7mg by mouth twice a day and [MEDICATION NAME] 100mg three tablets by mouth once a day. The most recent Care Plan reviewed for Resident #32 documented a focus on anti-anxiety medication use related to anxiety. Interventions for this focus included: monitoring and recording occurrence of target behavioral symptoms and document per facility protocol. Mood problems related to anxiety, [MEDICAL CONDITION] disorder and altered mental status were also among focuses addressed in the care plan. The interventions for this focus included; administering medications as ordered, monitoring and documenting for side effects and effectiveness. A record review for Resident #58 revealed that she was admitted into the facility on [DATE]. Her [DIAGNOSES REDACTED]. The orders for Resident #58 included: [MEDICATION NAME] 12.5mg by mouth at bedtime and [MEDICATION NAME] .25mg by mouth at bedtime. The most recent Care Plan reviewed for Resident #58 documented a focus on anti-anxiety medication use related to anxiety disorder. Interventions for this focus included: administering the anti-anxiety medication as ordered by physician and monitoring for side effects and effectiveness. Antipsychotic therapy was also among the focuses addressed. Interventions for this focus included: administering antipsychotic medication as ordered by physician and monitoring behavioral symptoms and side effects. Record review during the survey period from [DATE] through 3/5/2020 failed to reveal behavioral monitoring sheets for Resident #32 and Resident #58. During an interview with Employee L on 3/4/2020 at 10:08am she stated that she was not successful in locating the behavioral monitoring sheets for Resident #32. During an interview with the Assistant Director of Nursing (ADON) on 03/05/2020 at 5:39pm he confirmed that there were no behavioral monitoring sheets for neither of the residents (Resident #32 and Resident #58). He advised the survey team that behaviors were only documented for residents in the facility who receive as needed pain medications. .
F 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that care plans for 2 of 37 residents sampled, Resident #10 and Resident #66, were reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. The findings include: 1.Record review for Resident #10 revealed that she was admitted into the facility on [DATE]. Her last readmission was 12/25/2019. The [DIAGNOSES REDACTED]. Record review of the quarterly Minimum Data Set (MDS) assessment on 11/25/2019 revealed that Resident #10 had a brief interview for memory status (BIMS) score of 0/15 and required extensive assistance of one with eating. Record review of the most recent Care Plan for Resident #10 revealed that the interdisciplinary team failed to revise the Care Plan after the quarterly review assessment was completed for Resident #10 on 11/25/2019. The residents's activities of daily living (ADL) self-care performance deficit was addressed in the Care Plan which was initiated and last revised on 9/2/2019. The goals and interventions for eating were not appropriate for Resident #10's current functional eating status. 2.Record review for Resident #66 revealed that he was admitted into the facility on [DATE]. The [DIAGNOSES REDACTED].#66 had a BIMS score of 15/15 and required limited assistance of 1 person with eating. Record review of the most recent Care Plan for Resident #66 revealed that the interdisciplinary team failed to revise the Care Plan after the significant change assessment was completed for Resident #66 on 1/23/2020. The residents's activities of daily living (ADL) self-care performance deficit was addressed in the Care Plan which was initiated on 7/16/2019 and last revised on 11/19/2019. The goals and interventions for eating were not appropriate for Resident #66's current functional eating status. During an interview on 3/05/2020 at 12:28pm with Employee N, a Registered Nurse and Minimum Data Set coordinator when the surveyor asked if the Care Plans provided to the survey team were the most current for the residents Employee M responded; we are behind. She confirmed that the Care Plans had not been updated for Resident #10 and Resident #66. During an interview with

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F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) the Assistant Director of Nursing (ADON) on 03/05/2020 at 5:39pm he confirmed that the Care Plans provided to the surveyor team were the most recent for Resident #10 and Resident #66. He also confirmed that the interventions for eating had not been revised, did not reflect the resident's current condition and were not appropriate for the residents eating status. .
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to provide respiratory care according to the physician's orders and care plan for 1 of 1 residents receiving oxygen that were reviewed in a sample of 37 residents (Resident #8). The findings include: On 03/03/20 at 11:42 AM, Resident #8 was observed lying in bed, oxygen concentrator in the room, but no oxygen being administered as the concentrator was not turned on. Resident #8 stated he was supposed to be on oxygen all the time but was unsure of what his flow rate was supposed to be set on. A second observation on 03/03/20 at 12:44 PM was made and Resident #8 was observed in his bed, oxygen concentrator on, flow rate set at 3 liters per minute, nasal cannula present under nose. A third observation was made on 03/05/20 at 09:05 AM and Resident #8 was observed in his room, sitting up in the bed eating breakfast. Oxygen concentrator in the room was not turned on, oxygen tubing labeled and in a clear plastic bag hanging on the back of the concentrator. On 03/05/20 at 10:01 AM, an Interview with Employee E where she has been an employee for over a year and she works with Resident #8 several times a week. She also stated when working with resident's on oxygen she can apply the nasal cannula to the resident's nose, can bring a new oxygen tank to the room but can't switch an empty oxygen tank for a full tank or turn the tank on. On 03/05/20 at 10:27 AM, an interview was conducted with ADON about oxygen orders on Resident #8 where the ADON verified the physician had ordered oxygen to be administered via nasal cannula at 3 liters per minute. ADON also visually verified the oxygen concentrator was not on and the current orders were for oxygen at 3 liters per minute. At that time, ADON obtained a pulse oximetry reading of 92% on room air and notified Employee F of the oxygen saturation results. At that time ADON placed a nasal cannula on Resident#8 and oxygen concentrator was turned on and the flow rate was set at 3 liters per minute. On 03/05/2020 at 11:00 AM, an interview was conducted with Employee F. He stated his expectations for the nursing staff who noticed a change in a resident's condition or a medication mistake; he expects to be notified. A review of medical [DIAGNOSES REDACTED]. A review of physician orders for Resident #8 includes oxygen to run at 3 liters per minute via nasal cannula for shortness of breath. A review of Medication Administration Record [REDACTED]. A review of Minimum data set (MDS) with ARD on 2/25/2020 documents a brief interview of mental status (BIMS) score of 14 which indicates intact cognitive status. Also documents he needs extensive one person physical assistance for transfers and toilet use, and limited assistance of one person for bed mobility. Resident needs only set up help for eating. Review of the Care plan for Resident #8 documents the resident has oxygen therapy related to [MEDICAL CONDITIONS] with interventions of change residents position frequently to facilitate lung secretion movement and drainage, give medications as ordered by physician, position, position resident to facilitate ventilation/perfusion matching, prevent abdominal compression and respiratory embarrassment by routinely checking the residents position so that he does not slide down in bed, provide reassurance and allay anxiety: Have and agreed on method for the resident to call for assistance (e.g. call light, bell), .
F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review; the facility failed to ensure that it provided for an assessment of behaviors related to the administration of [MEDICATION NAME] and [MEDICATION NAME] for 1 (Resident #58) of 6 residents reviewed for unnecessary medication use out of a sample of 37 residents. Failure to appropriately monitor the effectiveness, side effects and resident behaviors following use of [MEDICAL CONDITION] medications can lead to dose and medication administration that are not appropriate for residents. The findings include: A record review for Resident #58 revealed that she was admitted into the facility on [DATE]. Her [DIAGNOSES REDACTED]. The orders for Resident #58 included: [MEDICATION NAME] 12.5mg by mouth at bedtime and [MEDICATION NAME] .25mg by mouth at bedtime. The most recent Care Plan reviewed for Resident #58 documented a focus on anti-anxiety medication use related to anxiety disorder. Interventions for this focus included: administering the anti-anxiety medication as ordered by physician and monitoring for side effects and effectiveness. Antipsychotic therapy was also among the focuses addressed. Interventions for this focus included: administering antipsychotic medication as ordered by physician and monitoring behavioral symptoms and side effects. During the survey period from [DATE] through 3/5/2020 record review for Resident #58 failed to reveal behavior monitoring sheets. During an interview with the Assistant Director of Nursing (ADON) on 03/05/2020 at 5:39pm, he confirmed that Resident #58 had orders for [MEDICATION NAME] and [MEDICATION NAME]. He also confirmed there were no behavior monitoring sheets for her. He advised the survey team that behaviors were only documented for residents in the facility who receive as needed pain medications. .
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and review of medical records and Medication Administration Record (MAR) review, the faciliy failed to ensure that it provided for a completed medical records related to physician ordered interventions for 6 (Resident #'s 39, 78, 32, 44, 72 and 104) residents out of a total of 37 residents sampled. The findings include: A review of the MAR dated for 02/01/2020 which indicated the medication administration documentation for Resident #39 for the 29 days in February. Ommited documentation which indicated a medication was administered or not admininstered based on the documented information. The following medications were not documented for Resident #39 on the dates listed: [MEDICATION NAME] 10 mg ordered to give one tablet by mouth daily was not documented as administered on 02/22 & 02/28/20. There was no documented note that indicated if Resident #39 received the medication. Atorvastatin 40 mg ordered to give one tablet by percutaneous endoscopic gastrostomy (PEG) tube once daily (at 9:00 PM) was not documented on 2/3, 2/4, 2/8, 2/9, 2/13, 2/17, 2/18, 2/19, 2/21, 2/22, 2/24, 2/26 & 2/27/2020.There was no available note or entry that indicated if Resident #39 received the medication. Carvedilol 25 mg ordered to give one tablet per PEG tube once daily (at 6:00 AM) was not documented on 2/8, 2/23 & 2/28/2020. There was no documented note that indicated if Resident #39 received the medication. A review of the reverse side of the MAR provided an area titled, Nurse's Medication Notes. The Nurse's Medication notes was reviewed by this Surveyor and Employee, A, RN on 03/04/2020 at 12:05 PM and the Unit Manager confirmed there was no documented note for review for any of the omitted medications for Resident #39. Employee A, RN also confirmed that documentation should have been completed. An interview was conducted with Resident #78 on 03/03/2020 at 9:25 AM. The resident stated that his doctor was concerned about his blood pressure because Resident #78 reported to the doctor that he did not get his medications as scheduled. Resident #78 also stated that his primary care doctor was going to adjust his medication; but, Resident #78 refused and told the doctor he was more concerned that he received the ordered medications before things got changed. An interview was conducted with Employee A, RN on 03/04/20 12:05 PM and confirmed that Resident #78 did not have the [MEDICAL TREATMENT] folder and Employee A, RN could not present the surveyor with complete documentation for pre and post [MEDICAL TREATMENT] care interventions and medication administration record documenation consisted of omissions in documented medication adminstration. A review of the medical record for Resident #78 documented: [MEDICAL TREATMENT]: M/W/F. Documented Davita Memorial Stretcher, Left Arm [MEDICAL TREATMENT] access; No (blood pressure) BP in Left arm. Fistula documented monitor on each shift for S/S of infection, if present document and notify (doctor) MD. Transported by a local service. Pick up time was documented to be 2:15 PM; return time 4:00 PM. May omit medications on [MEDICAL TREATMENT] days. Check for Bruit Thrill every shift and notify MD of complications. An interview was conducted with Employee M, LPN on 03/05/20 11:19 AM she provided that when Resident #78 returned from [MEDICAL TREATMENT] that they were supposed to get Vital Signs and provide an assessment for the site whether or not it was bleeding. Employee M, LPN

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Residents Affected - Some

(continued... from page 3)

referred the surveyor to Employee A, RN Unit Manager on 03/05/20 11:20 AM when she was asked to provide the [MEDICAL TREATMENT] Communication Book for Resident #78. Multiple daily notes and documentation were obtained and reviewed by Employee A, RN with the Surveyor and it was confirmed that the shunt was not being documented as assessed. There was multiple ommissions on the documents titled Daily Skilled Nurse's Notes and [MEDICAL TREATMENT] Communication Records for Resident #78 (Obtained copies.) A review of the care plan for Resident #78 was conducted and it was documented Resident needs [MEDICAL TREATMENT]. Monitor vital signs as ordered and as needed (prn). A review of the minimum data set for Resident #78 was conducted dated 02/04/2020. It documented that Resident #78 received [MEDICAL TREATMENT] while admitted to the facility and a brief interview for mental status (BIMS) score of 15 which indicated that Resident #15 was cognitively intact. A review of the following [MEDICAL TREATMENT] communication forms was conducted and was confirmed by Employee A, RN Unit Manager on 03/05/2020 at 11:20 AM as incomplete: 02/06/2020, 02/07/2020, 02/10/2020, 0[DATE], 0[DATE] and 02/21/2020. The ommitted information included vital signs, acess site assessment and signature of the nurse who completed the post [MEDICAL TREATMENT] assessment. A review of the following Daily Skilled Nurse's Notes was conducted and was confirmed by Employee A, RN Unit manager on 03/05/2020 at 11:20 AM as incomplete: 0[DATE], 0[DATE], 02/20/2020, 02/21/2020, and 0[DATE]20. The ommitted information included a completed vascular access site assessment. A review of the facility policy and procedure for the coordination of [MEDICAL TREATMENT] services documented at line #1 under procedure that The [MEDICAL TREATMENT] Communication form will be initiated by the facility for any rsident going to End Stage [MEDICAL TREATMENT] (ESDR) center for [MEDICAL TREATMENT]. Line #2 documented as policy and procedure that Nursing will collect and complete the information regarding the resident to send to the [MEDICAL CONDITION] Center. Line #r Documented upon the resident's return to the facility nursing will review the [MEDICAL TREATMENT] Communication and information completed by the [MEDICAL TREATMENT] center OR the information sent by the [MEDICAL TREATMENT] center; communicate with the resident's physician and other ancillary departments as needed, implement interventions as appropriate. Line #5 documented Nursing will complete the post [MEDICAL TREATMENT] information on the [MEDICAL TREATMENT] Communication form and file the completed form in the Resident's Clinical Record. A record review for Resident #32 revealed that she was admitted into the facility on [DATE]. Her [DIAGNOSES REDACTED].#32 included: [MEDICATION NAME] 100mg by mouth twice a day; [MEDICATION NAME] 7mg by mouth twice a day and [MEDICATION NAME] 100mg three tablets by mouth once a day; [MEDICATION NAME]-[MEDICATION NAME] 7.5-325mg by mouth four times a day. The most recent Care Plan reviewed for Resident #32 documented a focus on anti-anxiety medication use related to anxiety. Interventions for this focus included: monitoring and recording occurrence of target behavior symptoms and document per facility protocol. Mood problems related to anxiety, [MEDICAL CONDITION] disorder and altered mental status were also among focuses addressed in the care plan. The interventions for this focus included; administering medications as ordered, monitoring and documenting for side effects and effectiveness. Record review of the MAR and the controlled medication utilization record for the [MEDICATION NAME]-[MEDICATION NAME] 7.5-325mg revealed that MAR and the controlled medication utilization record were inconsistent. The controlled medication utilization record reflected that from 2/7/2020 through 2/29/2020 the medication was signed out 81 times. The MAR reflects 23 administrations of the medication during this time period. During an interview on 3/04/2020 at 9:50am with Employee M, a Licensed Practical Nurse (LPN) she confirmed the inconsistencies in both documents. She stated; the MAR may not be correct as some nurses forget to update. During an interview with the ADON on 3/05/2020 at 12:14pm he reviewed both documents and stated; the narc sheet doesn't match the administration report. He stated that the documents should match. He also stated; the administration report doesn't match the pain flow sheet. He stated that the nurses should be documenting that on the MAR when medication is given. He stated that the nurses should be counting the narcotics during shift change and that if there is an extra pill they should identify it with the DON or their supervisor at the time.

Review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) dated from 02/01/2020 through 02/29/2020 for Resident #44 revealed: Blood pressure and pulse every shift was blank on the 7PM-7AM shift on 02/04/2020, 02/05/2020, 02/08/2020, 0[DATE] and on 02/19/2020. On the 7AM -7PM shift, the MAR was blank on 02/05/2020, 02/07/2020, 0[DATE], 0[DATE], 02/20/2020, 02/21/2020, 02/25/2020, 02/26/2020 and 02/29/2020 (Copy obtained). Carvedilol 3.125 mg tablet. Give 1 tablet per [DEVICE] (gastrostomy tube) twice daily for hypertension. 6 AM and 5 PM. For the 6 AM dose, the MAR was blank on 02/04/2020, 02/05/2020, 02/06/2020, 02/08/2020, 0[DATE], 02/15/2020, 02/16/2020 and 02/19/2020. For the 5 PM dose the MAR was blank on 02/02/2020, 02/06/2020, 02/07/2020, 02/09/2020, 02/10/2020, 02/11/2020, 02/12/2020, 02/16/2020, 02/22/2020, 02/25/2020 and 02/28/2020 (Copy obtained). [MEDICATION NAME] 75mg tablet. Give 1 tablet per peg tube once daily at 6 AM. The MAR was blank on 02/02/2020, 02/03/2020, 02/08/2020, 02/13/2020, 02/15/2020 and 02/19/2020. [MEDICATION NAME] 1.2 at 53 ml/hour x 19 hours from 2PM-9AM to provide 1007 total Kcal for dysphagia. The MAR was blank on 0[DATE] and 02/16/2020 (Copy obtained). Skin assessment weekly on Monday (Shift 11-7). The TAR was blank for each Monday in the month (Copy obtained). Review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) dated from 03/01/2020 through 03/04/2020 for Resident #44 revealed: Atorvastatin 10 mg tablet. Give 1 tablet per peg tube at bedtime for [MEDICAL CONDITION] at 9PM. The MAR was blank on 03/02/2020 (Copy obtained). [MEDICATION NAME] 220 mg/5ml [MEDICATION NAME]. Give 7.5 ml (330mg) per [DEVICE] once daily for [MEDICAL CONDITION] at 6 AM. The MAR was blank on 03/03/2020 (Copy obtained). [MEDICATION NAME] HCL 100mg tablet. Give 1 tablet per [DEVICE] once daily at 6 AM. The MAR was blank on 03/03/2020 (Copy obtained). Review of the MAR and TAR for Resident #44 for the months of February and March 2020 revealed multiple blanks on the document where the nursing staff should have initialed the document indicating the administration of medications or treatments was conducted. Review of the back of the MARs and TARs revealed no documentation to explain the blanks (Copies obtained). A Review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) dated from 02/01/2020 through 02/29/2020 for Resident #72 revealed: Atorvastatin 80 mg tablet. Give 1 tablet per [DEVICE] at bedtime for cholesterol. 9PM. The MAR was blank on 02/01/2020, 02/02/2020 and 02/07/2020 (Copy obtained). [MEDICATION NAME] 75 mg tablet. Give 1 tablet per [DEVICE] once daily for [MEDICAL CONDITION]. The MAR was blank on 0[DATE] (Copy obtained). Aspirin 81 mg chewable tablet. Give 1 tablet per [DEVICE] once daily. The MAR was blank on 0[DATE] (Copy obtained). [MEDICATION NAME] HBR 10mg tablet. Give 1 tablet by mouth once daily. 9PM. The MAR was blank on 02/13/2020 (Copy obtained). [MEDICATION NAME] 50 mcg tablet. Give 1 tablet per [DEVICE] once daily for hypertension. 6AM. The MAR was blank on 0[DATE] (Copy obtained). [MEDICATION NAME] 10mg tablet. Give 1 tablet per [DEVICE] twice daily for hypertension. 6AM and 9PM. The MAR was blank on 02/01/2020, 02/02/2020 and 02/13/2020 (Copy obtained). [MEDICATION NAME] 100mg tablet. Give 1 tablet per [DEVICE] twice daily. 6AM and 9PM. The MAR was blank on 02/01/2020, 02/02/2020, 02/13/2020and 0[DATE] (Copy obtained). [MEDICATION NAME] 50mg tablet. Give 4 tablets (200mg) per [DEVICE] three times daily. 6AM, 2PM and 10PM. The MAR was blank on 02/01/2020, 02/02/2020 , 02/13/2020, 0[DATE] and 0[DATE]20 (Copy obtained). [MEDICATION NAME] trough level on 02/13/2020. The MAR was blank on 02/13/2020 (Copy obtained). Review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) dated from 03/01/2020 through 03/04/2020 for Resident #72 revealed: [MEDICATION NAME] 100mg tablet. Give 1 tablet per [DEVICE] three times daily for hypertension. 6AM, 2PM and 10PM. The MAR was blank on 03/02/2020 for the 6AM and 2PM doses, 02/03/2020 for the 2PM dose and on 02/04/2020 for the 2PM dose. (Copy obtained). [MEDICATION NAME] 100mg tablet. Give 1 tablet per [DEVICE] twice daily. 6AM and 9PM. The MAR was blank on 03/02/2020 for the 6AM dose (Copy obtained). [MEDICATION NAME] 50mg tablet. Give 4 tablets (200mg) per [DEVICE] three times daily. 6AM, 2PM and 10PM. The MAR was blank on 03/02/2020 for the 2PM dose, 03/03/2020 for the 2PM dose and on 03/04/2020 for the 6AM dose and 2PM dose Copy obtained). [MEDICATION NAME] 50 mcg tablet. Give 1 tablet per [DEVICE] once daily for hypertension. 6AM. The MAR was blank on 03/02/2020, 03/03/2020 and 03/04/2020 (Copy obtained). A Review of the MAR and TAR for Resident #72 for the months of February and March 2020 revealed multiple blanks on the document where the nursing staff should have initialed the document indicating the administration of medications or treatments was conducted. Review of the back of the MARs and TARs revealed no documentation to explain the blanks (Copies obtained). A Review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) dated from 02/01/2020 through 02/29/2020 for Resident #104 revealed: [MEDICATION NAME] 100mg by mouth daily. 9AM. The MAR was blank from 02/20/2020 through 02/28/2020 (Copy obtained). [MEDICATION NAME] 250 mg by mouth twice a day. 9AM and 5 PM. The MAR was blank from 02/20/2020 through 02/28/2020 (Copy obtained). Catheter care with soap and warm water every shift an as needed. 7 AM to 3PM, 3PM to 11 PM and 11 PM to 7 AM. The MAR was blank 02/01/2020 through 02/06/2020 all three shifts, from 02/08/2020 through 02/16/2020 all three shifts, 0[DATE], 02/19/2020, 02/28/2020 and 02/29/2020 all three shifts. (Copy obtained). Monitor urine for signs and symptoms of infection, if present document and notify MD (physician). 7 AM to 3PM, 3PM to 11 PM and 11 PM to 7 AM. The MAR was blank on the 7AM-3PM shift from 02/01/2020 through 02/16/2020, 0[DATE] through 02/29/2020. The MAR was blank on the 11PM to 7AM shift on 02/04/2020, 02/08/2020 through 02/16/2020, 0[DATE] and 02/19/2020, 02/21/2020 and 02/28/2020 and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105917	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CONSULATE HEALTH CARE OF JACKSONVILLE	4101 SOUTHPOINT DRIVE EAST JACKSONVILLE, FL 32216

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 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) 02/29/2020 (Copy obtained). [MEDICATION NAME] [MED] 15 units subcutaneous daily for diabetes mellitus. 9PM. The MAR was blank on 02/21/2020 (Copy obtained). Review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) dated from 03/01/2020 through 03/04/2020 for Resident #104 revealed: Catheter care with soap and warm water every shift an as needed. 7 AM to 3PM, 3PM to 11 PM and 11 PM to 7 AM. The MAR was blank all three shifts on 03/03/2020 and 03/04/2020 (Copy obtained). Monitor urine for signs and symptoms of infection, if present document and notify MD (physician). 7 AM to 3PM, 3PM to 11 PM and 11 PM to 7 AM. The MAR was blank on all three shifts on 03/03/2020 and 03/04/2020 (Copy obtained). [MEDICATION NAME] Sodium 100mg soft gel. Give 1 capsule by mouth twice daily for constipation. 9AM and 5PM. The MAR was blank for the 5PM dose on 03/03/2020 (Copy obtained). Dorzolamide [MEDICATION NAME] eye drops. Instill 1 drop into right eye twice daily. 9AM and 5 PM. The MAR was blank for the 5PM dose on 03/03/2020(Copy obtained). Review of the MAR and TAR for Resident #104 for the months of February and March 2020 revealed multiple blanks on the document where the nursing staff should have initialed the document indicating the administration of medications or treatments was conducted. Review of the back of the MARs and TARs revealed no documentation to explain the blanks (Copies obtained). During an interview with Employee D, Assistant Director of Nursing (ADON) on 03/04/2020 at 10:44 AM he reviewed the MAR for Resident #44 and acknowledged that the staff had not completed the documentation for administration of medications. He stated he had conducted in-service trainings for the staff recently on documenting properly in the clinical record. On 03/05/2020 at 2:10 PM, the ADON produced an in-service for the nursing staff on documentation in the clinical record. Review of the form revealed the training was entitled Nurses Meeting 02/27/2020 and the sign in sheet was dated 02/27/2020. The topics covered included: Documentation - skilled and monthly charting requirements. Skilled documentation - sticker system. Skin checks and body audits. Medication availability, omissions in the medication administration record and treatment administration record, and the narcotic count at shift change. He stated that he has been conducting trainings with the nursing staff for several months (Copy obtained). Review of the facility policy and procedure entitled Medication -Oral Administration of N-853 effective 11/30/2014 and revised on 08/15/2019 read: Prepare the medication for one resident at a time. Document the administration and acceptance or decline of all medications administered. This may include a. When documenting on a hard copy MAR (non electronic), the nurse will document immediately prior to administration and or immediately post administration based on preferred individual professional practice of the nurse. Should the resident decline or be unable to accept the medication this will need to be documented following standard protocol (Copy obtained). .
F 0867 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.** Based on observation, interview and document review, the facility failed to ensure that it developed and implemented an appropriate plan of action to correct identified quality deficiencies for the omission of documentation on resident medical records and medication administration records (MAR) for (6) (Resident #'s 39, 78, 32, 44, 72 and 104) out of 37 sampled residents. The findings include: An entrance conference was conducted with the facility Administrator, Director of Nursing (DON) and the Assistant Director of Nursing (ADON) on 03/02/20 at 10:17 AM. During the entrance conference a list of Quality Assurance and Process Improvement (QA/PI) projects was requested with the QA/PI plan. The list of QA/PI projects was provided to the Surveyor on 03/04/2020 at 3:45 PM. There were 20 items documented as part of the list of projects. Line 5 documented Medical Records and line 7 documented Medication Administration. On 03/05/2020 a recertification survey was conducted and revealed that 6 residents (Resident #'s 39, 78, 32, 44, 72 and 104) were identified to have multiple omissions in medical records which included resident MAR's. During pre-survey preparation, it was documented that the facility had a complaint investigation conducted on 09/26/2019 and that resulted in a citation level concern at F-0842 related to 1 of 3 Residents sampled had omissions related to interventions as part of the medical record. The facility responded to the complaint findings with a documented Plan of Correction (POC) to correct omissions in the facility medical records and the activity was documented as part of the facility's Quality Assuranc and Process Improvment (QA/PI) activity. The facility documented corrective action included that the Director of Clinical Services completed a quality review for active residents for omissions in medication administration records. Staff education was documented as provided to licensed nurses for omissions in medical adminstration record. Re-education was documented provided to nursing on 10/18/2019. It was also documented that Licensed nurses were re-educated on 08/22/2019, 09/25/2019 and 10/18/2019, and ongoing by Director of Clinical Services/Designee with an emphasis on omissions in medication administration records. It was also documented that newly hired clinical staff would receive education in orientation. The facility also documented that the Director of Clinical Services/Designee would conduct a quality review of 5 residents on each unit MAR to ensure they are free from omissions weekly X 4 weeks, then monthly X 2 months. The reviews were reported to the Quality Assurance/Performance Improvement Committee until the committee determined substantial compliance was met. A review of minute meetings from the facility QA/PI activity documented on 1[DATE]19 under the section marked as Data (Assess Current Situation-what were the results/trend) during the Quality Assurance & Performance Improvement meeting with a 1:30 PM start time on, date (1[DATE]19). On 09/26/2019 the QA/PI meeting results documented, Follow up visit from previous citations - results: F-842 Resident Record MAR Citation as it pertains to Omissions in the Medication Record. (Analysis: Root Cause Analysis) it was noted, The facility was back in total compliance. Documented plan included Documentation-Education/top 10. An interview was conducted with the Administrator on 03/05/2020 at 4:37 PM. The Administrator confirmed that the facility had been discussing the missing documentation and nursing meetings in December 2019 related to similar concerns with medication administration and audits were not available at the time. During the interview with the Administrator, DON and ADON, they stated for the medication administration projects, staff was assessed for medication omissions and timeliness of the administration of medication. The DON and ADON stated that they compared the MAR and documented reconciliation. The Administrator stated on 03/05/20 at 4:23 PM that they were finding holes in the MAR. Depending on the finding, if the resident was impacted or not, staff who were identified as having omitted information from the resident record were provided 1:1 education and it was determined if staff would be written up or considered for termination. A request to review the corrective action that occurred after the QA/PI meeting dated December 24, 2019 which identified that the facility was fully compliant with medical record omissions was made. No corrective action was identified at the time of survey interviews. Four point plans reviewed initiated by QA/PI dated 01/28/2020, a form was reviewed related to timeliness of medication. This plan did not identify omissions in the facility resident medical records which included a review of MAR's and it was documented: Point 1 used Resident #3 for a late pain medication administration. Pain needs were being met; step two was a whole house audit of residents; the whole house audit included quality review of current resident medication administration times to ensure medications were administered per (doctor) MD order and regulation. The DON stated that in February the MAR's looked pretty tight and did not sample any residents with omissions in the MAR. It was reviewed that in September 2019 F - 0842 was identified as deficient in practice related to omissions in the medication administration record and the DON stated that, I cannot speak to the earlier DON's work. A review of the January 2020 quality meeting documented in attendance the facility Administrator and DON. It was reviewed and documented use of previous Plan of Correction (POC) documented with omission of medical record data. An interview was conducted with the DON on 3/05/20 at 04:43 PM and she stated that they only had an audit tool and no data to back up the audit. A review of the January 29, 2020 QA/PI Agenda Meeting was conducted and documented present at the meeting was the Medical Director, Administrator, DON and ADON. The meeting documented areas addressed as Regulatory Readiness; All system Champions, Report, Plan and Progress included Perform Mock Survey on 400/500 hall daily to prepare for annual survey. A review of an added on March 02, 2020 Ad Hoc Quality Assurance & Performance Improvement Meeting was presented to the surveyor For March 2020 that documented the opportunity for improvement to ensure accuracy and completeness of the medical records. Data included. An interview with DON was conducted on 03/05/3030 at 6:15 PM and stated there were no concerns with her sample; the audits were perfect and confirmed that they did not audit the whole building, but would. An interview was conducted with the ADON on 03/05/2020 at 6:33 PM, the ADON stated that the facility had challenges in February 2020. The ADON stated around February 12, 2020 the facility became aware of medical record holes because he worked the cart one day. He initiated education in February 2020 related to medication; there was no new QA/PI that specifically indicated the quality committee had addressed incomplete medication administration records following the December 24, 2020 compliance documented by QA/PI until the Ad Hoc meeting that was documented on March 02, 2020. The survey team entered the facility on March 02, 2020 at 10:00 AM and conducted the entrance conference. Based on observation, interview and review of medical records and Medication Administration Record

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	105917	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CONSULATE HEALTH CARE OF JACKSONVILLE	**4101 SOUTHPOINT DRIVE EAST JACKSONVILLE, FL 32216**

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

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F 0867 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 5) (MAR) review; the faciliy failed to ensure that it provided for a completed medical record related to physician ordered interventions for 6 (Resident #'s 39, 78, 32, 44, 72 and 104) residents out of a total of 37 residents sampled. (Reference F-0842 a repeated concern since September 29, 2019 and indicated since December 24, 2019 QA/PI meeting that cleared the facility for omissions in the medical records, omissions were identified In January 2020, February 2020 and March 2020 which occurred after the completion of QA/PI activity.)