STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106024	A. BUILDING _____ B. WING _____	**09/24/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ADVENTHEALTH CARE CENTER ORLANDO NORTH	**730 COURTLAND STREET ORLANDO, FL 32804**

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 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to obtain a physician's order for Advance Directives for 1 of 3 residents out of a total sample of 36 residents, (#66). Findings: Resident #66 was initially admitted to the facility on [DATE] then readmitted on [DATE]. Her [DIAGNOSES REDACTED]. The 5-day Minimum Data Set (MDS) assessment with reference date [DATE] indicated that resident #66 had a Brief Interview for Mental Status (BIMS) of ,[DATE] which indicated moderate cognitive impairment. The Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form Agency for Health Care Administration ,[DATE] completed by the hospital dated [DATE] indicated that resident #66 was capable to make healthcare decisions. The Advance Care Planning (Section H) listed yes to the following items: Advance Directive, Living Will and DO NOT Resuscitate (DNR). The admission record indicated that her Advance Directive was Do Not Resuscitate. Record review of Advance Directives/do not resuscitate acknowledgement form (page 1 of 3) indicated that the facility's ability to honor resident's decision regarding cardiopulmonary resuscitation .we will be implementing a process to readily recognize your choice. If a resident experiences cardiac or respiratory arrest, cardiopulmonary resuscitation (CPR) will be initiated if a purple colored Do Not Resuscitate (DNR) wristband is NOT present or if the code status is not IMMEDIATELY known. If a valid DNR order is presented, CPR will be stopped in accordance with state guidelines. A telephone consent from resident representative was obtained on [DATE]. Physician order summary report printed on [DATE] did not indicate a Do Not Resuscitate Order. Care plan initiated on [DATE], revised on [DATE] revealed that resident #66's advance directives were as follows: Do not resuscitate, health care proxy, and letter of incapacity. Interventions were to complete/update advance directives document and purple DNR wristband to right wrist. On [DATE] at 10:36 AM, resident #66 was observed laying in bed, still dressed in night gown, with eyes closed. There was no purple wristband observed on either upper or lower extremities. On [DATE] at 10:40 AM, Registered Nurse (RN) D stated that for newly admitted residents, the nurse was expected to perform a full assessment from head to toe. She stated there was a checklist of all the forms that needed to be completed upon admission or readmission from the hospital. She said she was also responsible to ensure that the orders from the hospital were carried out correctly. Since she had been in the facility for less than a year, she always asked the Unit Manager (UM) to double check her work to make sure she did not miss anything. She noted that if a resident had a DNR order, a purple band was to be applied to the wrist. She added if in case the resident refused the band to be placed on the wrist, it had to be placed on the lower extremities, top part of the headboard or footboard. She said resident #66 had a purple wristband but was not sure if it was on her right or left wrist. [DATE] at 8:47 AM, the Admission Director stated that prior to admission/readmission, it was important that all medical records be obtained from the hospital including Form 3008, discharge orders, medication reconciliation sheets and COVID-19 ([MEDICAL CONDITION] Disease 2019) status. The Admission Coordinator stated that she was expected to meet the new resident within 24 hours to ensure the admission contract was discussed, explained and signed by the resident or his/her health care proxy or family representative. She said she was responsible to obtain a copy of DNR (yellow form) and Power of Attorney (POA) documentation. The nurses were supposed to ensure that the discharge orders were carried out correctly. On [DATE] at 9:38 AM, the Social Service Director (SSD) stated that admission assessments had to be performed within 48 hours. Some of these assessments were determination of BIMS, cognitive assessment, mood assessment, social history and discharge planning. She also stated that she would discuss Advance Directives with the resident (full code versus DNR). If the resident was alert and decided DNR, a form would be provided for his/her signature, then it had to be signed by the physician. On [DATE] at 10:02 AM, resident #66 was observed laying in bed, alert, and dressed in night gown. There was no purple wristband observed on either right or left upper or lower extremities. At 10:47 AM, Licensed Practical Nurse (LPN) E was asked about resident #66's code status. LPN E searched the records in the computer and stated there was no code status listed. The LPN was asked what she would do if she walked in the resident's room and found the resident unresponsive. LPN E replied if she does not have a purple bracelet, I would perform CPR on the resident. Both UM and LPN E did not remember what the resident's code status was prior to being sent to the hospital on [DATE]. On [DATE] at 10:52 AM, the UM acknowledged that resident #66 did not have a code status ordered. She also stated she was not sure what happened and why the order was dropped when the resident was readmitted from the hospital. On [DATE] at 12:24 PM, the Director of Nursing (DON) stated that nurses were responsible to obtain orders from the hospital prior to admission. They were supposed to call the physician or designee and review all orders with them. If the resident was a DNR, a purple band had to be placed on the resident. She also stated that even if there was a purple band, the nurses were still expected to validate the resident's code order. She said if a resident was admitted from the hospital and there was no DNR order, the resident would be full code status. She verified that according to the nurse practitioner's progress notes, the resident was supposed to be DNR.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation and interview, the facility failed to ensure proper storage of ready to eat foods in the walk-in refrigerator and frozen foods in the walk-in freezer. The facility also failed to prevent contamination of the eating surface of small bowls. Findings: On 09/21//20 at 9:45 AM, the walk-in refrigerator and walk-in freezer revealed foods stored directly under the blower fan units without a barrier to protect the foods from potential contamination from condensation that could leak onto the products. Ready to use loose bags of shredded cheddar cheese, mascarpone cheese and sliced cheese were noted stored under the blower fans in the walk-in refrigerator unit. The freezer unit had boxes of dinner rolls stored directly under the freezer fan blower. On 9/21/20 at 12:15 PM, the dietary manager said the products should not have been stored directly under the blower. On 9/21/20 at 12:16 PM, during the lunch meal trayline, cook C reached for soup bowls from the storage rack. She turned the bowls over and placed her fingers inside the bowls. She prepared other plates for residents, touching the counter and serving handles of the foods served. She was asked to demonstrate how she picked up the bowls to fill with food. She again touched the inside surfaces of the bowls. At 12:30 PM, the dietary manager stated she observed cook C touching the inside of the bowl. She added that staff had been trained not to touch eating surfaces of the dishware.
F 0908 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Keep all essential equipment working safely.**

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 0908 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) Based on observation, interview and record review, the facility failed to ensure that the mechanical dishwasher was maintained in proper working condition to wash dishes, silverware and glassware used by the residents and failed to maintain appropriate rinse pressure for the high temperature dishmachine. Findings: On 09/21//20 at 9:35 AM, the kitchen staff were washing the breakfast dishware in the dish washing machine. A cycle of the machine was observed. The wash temperature was 135 degrees Fahrenheit (F) and the rinse temperature was 181 degrees F. Inspection of the machine revealed one of the lower dish arms disconnected from the machine preventing proper washing of the dishes. Observation of the pressure gauge used to monitor the water pressure during the rinse cycle revealed no reading. Dietary aide A was not aware the pressure had to be monitored. Review of the temperature monitoring log for the month of September 2020 did not have any monitoring documentation of the pressure of the rinse cycle. On 9/23/20 at 11:53 AM, the Dietary Manager stated they were not monitoring the pounds per square inch (PSI) pressure of the dishmachine. She was also not aware what the proper PSI should have been. Review of the operating manual for the dishmachine noted the optimum flow pressure should have been 20 PSI. Review of Centers for disease Control (CDC) environmental health operations manual chapter 13.7,Warewashing evaluation pressure gauge for the in line hot water injection point pressure should be 15-25 PSI. (HTTPS://www.cdc.gov/nceh/vsp/operationsmanual/opsmanual2000.pdf)