STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106011	A. BUILDING _____ B. WING _____	**08/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CONSULATE HEALTH CARE OF KISSIMMEE	**2511 JOHN YOUNG PARKWAY NORTH KISSIMMEE, FL 34741**

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 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide dressings to cover a stage IV sacral/coccyx pressure ulcer (PU) for an incontinent resident (#2), failed to obtain PU orders to cleanse and dress a stage IV PU at a resident's readmission (#2), failed to timely obtain PU measurements and orders to treat a newly admitted resident with a right heel stage II blister PU (#1), and failed to timely order a pressure relieving boot for use in therapy as recommended by the wound care physician (#1) for 2 of 3 sampled residents reviewed with pressure ulcers (#1 & #2). A stage IV Pressure Ulcer is a full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible on some parts of the wound bed. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the wound bed, it is an unstageable PU/PI (pressure injury) (CMS). A stage II Pressure Ulcer is a partial-thickness skin loss with exposed dermis. Partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink or red, moist, and may also present as an intact or open/ruptured blister (CMS). Findings: 1. Resident #2 was originally admitted to the facility on [DATE]. On 7/15/2020, she was admitted to the hospital with [REDACTED]. On 7/15/2020, prior to her hospital admission, resident #2's sacral PU had measured at 2.2 centimeters (cm.) in width by 0.8 cm in width by 0.5 cm in depth. The wound care physician had documented the PU as unavoidable. On 8/07/2020 at 11 PM, resident #2 was readmitted to the facility. Her readmission [DIAGNOSES REDACTED]. Review of her nursing admission data collection dated 8/07/2020 described her sacral PU as follows: Sacrum .small wound. There were no measurements and no detailed description of the PU in the nursing admission data collection and/or the medical record since the resident's readmission on 8/07/2020. There was not any evidence in the medical record that the wound care physician had reevaluated her since she was readmitted to the facility. On 8/13/2020 at 11 AM, observation of resident #2 with the director of nursing (DON) revealed that she was resting in bed. She wore an incontinence brief. The DON removed the left side of the resident's incontinence brief and resident #2's sacral/coccyx area was observed. It was not covered by a dressing. The DON validated this finding and indicated that the PU needed to be covered with a dressing to prevent potential infection from the resident's bowel incontinence. The pressure ulcer was tear dropped in shape and was visualized to measure approximately 5 cm. in length by 3 cm. in width by 1.5 cm. in depth. There was a small amount of yellowish colored slough in the bed of the wound. Fat and muscle tissue were visible. At 11:10 AM, interview with the resident's CNA A stated said that she had washed up the resident about 9:30 AM. She had observed at that time, there was not a dressing covering the PU. CNA A said she washed the resident's bottom and PU with soap and water, put on a clean adult incontinence brief, and then told nurse B there was no dressing covering the PU. CNA A said that resident #2 was incontinent of bowel and bladder. She said the 11-7 shift CNA had not mentioned to her that there was not a dressing covering the PU. At 11:15 AM, interview with Nurse B stated that CNA A had informed her that resident #2's PU did not have a dressing on it. She said that she had not yet been able to get to it as of yet. Resident #2's most recent minimum data set assessment (MDS) was a quarterly and dated 6/16/2020. It revealed that the resident was always incontinent of bowel and bladder, that she required extensive to total care from staff for her activities of daily living needs which included personal hygiene and toileting needs. It revealed that she had severe cognitive impairment. Her brief interview mental status assessment score was 1 out of 15. She had one stage IV PU. On 8/13/2020 at 11:50 AM, during an observation of the pressure ulcer treatment with Nurse C/MDS Coordinator revealed that she cleansed the sacral/coccyx PU with normal saline, applied Hydrogel to the wound bed, applied skin-prep to the PU's per-area, and then covered the wound with an occlusive dressing. CNA A and CNA D assisted resident #2 with positioning needs during the treatment and dressing application. The DON was in attendance. After the PU treatment, the orders were reviewed with Nurse C and the DON. The sacral/coccyx PU order, dated 8/07/2020, read, Hydrogel Gel, Apply to Coccyx topically every day shift related to PU of sacral region, stage IV. It did not include an order to cleansing and dress the PU. Nurse C and the DON validated there was no order for cleansing and dressing of the PU. The DON said the nurse needed to obtain an order to cleanse and cover the PU. She said sure was not sure what had happened that the order was incomplete. On 8/13/2020 at about 4 PM, the DON validated that there had not been any PU measurements documented at resident #2's readmission or since her readmission. The DON said the expectation was that at admission PUs would be described in detail and measurements taken. She said that a registered nurse needed to stage PUs, but that LPNs could describe and measure them. She said that their former wound care nurse had resigned a couple months prior and that the facility was in the process of recruiting a new wound care nurse. The facility's PU policy and procedure Clinical Guideline for Skin & Wounds, revised 4/01/2017, read, Residents will have a pressure ulcer injury record completed for each skin impairment that is pressure . Enter the stage of the pressure injury .Enter the size of the pressure injury - length x width x depth in centimeters .Enter the tissue type and color .Enter the wound edges and drainage .Enter the peri-wound information .licensed nurse to sign the appropriate area. 2. Resident #1 was admitted to the facility on [DATE] for short term care therapy falls at home and a hospitalization that included gastroenteritis and weakness. [DIAGNOSES REDACTED]. On 5/14/2020, a skin integrity review was conducted by the former wound care nurse. The assessment revealed that when resident #1 was admitted to the facility, he had a large serous filled ulcer on his right heel. Two days prior to the skin integrity review, on 5/12/2020, resident #1's admission data assessment revealed the admitting nurse had not documented and described the right heel blister with its measurements. Resident #1's physician orders did not contain a treatment and dressing order for the right heel blister until 5/20/2020, eight days after he was admitted to the facility, when he was seen by the wound care physician. On 5/20/2020, the wound care physician determined that the right heel blister had a callous pairing that had developed eschar and 10% slough. The physician performed a surgical debridement of the PU on 5/20/2020, and then staged it as IV. Post debridement, it measured 6.5 cm. in length by 7 cm. in width by 0.5 cm. in depth. According to the 5/20/2020 wound care progress note, the right heel PU treatment and dressing were initiated on 5/20/2020. This was the first time an order had been obtained for the right heel PU since resident #1's admission 8 days earlier. The 5/20/2020 treatment order read, Right heel cleanse with normal saline, apply Hydrogel, [MEDICATION NAME], and cover with Kerlix dressing every other day and as needed. Resident #1's TAR revealed that no right heel PU treatments were given to the resident prior 5/20/2020. Slough is non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed. (CMS). Continued review of the above 5/20/2020 wound care physician's note for resident #1 included the following recommendation: Float heels and Recommend Heel Offloading Boots for physical therapy. Specialty Devices for Feet .Heel Protector. There was no order in the medical record for the offloading specialty boot. A physical therapy progress note dated 5/25/2020 read, Patient able to walk with distances however due to high right heel wounds, MD (medical doctor) recommended WBAT (weight bearing as tolerated) with heel wedge shoe to avoid further pressure from right heel Patient demonstrates progress towards established goals, with noted improvements in all aspects of functional mobility and gait performance. Patient currently seen by wound doctor for right

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 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) heel wounds, recommended WBAT with right heel wedge shoe. Physical therapist informed supervisor, provided copy of the shoe to order as ASAP (as soon as possible). On 5/27/2020, the wound care physician again saw resident #1. The right heel measurements at this time were 3 cm x 3 cm x 0.5 cm, and stage IV. The progress note read, Wound improving, changing treatment to Santyl from scant Hydrogel and [MEDICATION NAME]. Patient with multiple co-morbid conditions and right lower leg weakness who presented with a right heel pressure injury on admission. The wound was initially a large fluid filled blister that was drained and debrided at bedside, revealing underlying necrotic tissue The heel PU was surgically debrided at bedside on 5/27/2020. The 5/27/2020 wound care physician's note for resident #1 included the same above recommendation for the heel offloading boot specialty device for use during physical therapy. There continued to be no order found in the medical record for the offloading specialty boot. On 8/13/2020 at 2:39 PM, interview with therapy director validated the above 5/20/2020 and 5/25/2020 physical therapy notes regarding the wound care physician's recommendation for the right heel off-loading wedge boot for resident #1 to be used during therapy. He validated that the PT had informed him about the recommendation for the boot. He said that the resident's weight bearing exercise on the right foot had been put on hold until the wedge shoe was delivered. He thought the boot was ordered on [DATE] or 5/26/2020. He was not sure what happened regarding the delay in ordering the boot on 5/20/2020. He said the administrator was responsible to order therapy boots, not the therapy department. He said that he had made the administrator aware of the resident's need for the boot, and the administrator is no longer at the facility. The therapy director said it takes about 4-5 days for a boot, once ordered, to be delivered to the facility. He validated that resident #1 had been discharged to the hospital on [DATE], a 17 day stay. He said the resident did not return to the facility and did not receive the boot to wear for therapy services. He said the boot is in the therapy gym and will be used for another patient when needed. Resident #1's admission MDS dated [DATE] revealed had received PT and occupational therapy (OT) services. It also revealed that he had a PU present at admission. On 8/13/2020 at 2:45 PM, the DON validated that resident #1's right heel PU assessment and PU orders had not been obtained timely for resident #1. The DON said that she had called the admitting nurse three times regarding the lack right heel pressure ulcer documentation on the 5/12/2020 nursing admission data collection. She said he had not yet returned her calls. The DON said the wound care nurse, who had conducted resident #1's 5/14/2020 skin integrity review and who had not obtained a PU order, was no longer at the facility. The DON said that it was the expectation of the facility that upon discovery of a PU, it would be described and measured, then orders obtained and initiated. The DON indicated that the wound care nurse or person assigned to round with the wound care physician would be responsible for making sure treatment order recommendations during wound rounds were documented and placed in the medical record.
F 0692 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to timely provide a diabetic therapeutic diet to a short-term care (STC) resident who was insulin dependent; did not obtain a physician's orders [REDACTED].#1). Findings: Review of resident #1's medical records revealed that he was admitted to the hospital from home on 5/5/2020. A cardiac physician's progress from the hospital, dated 5/07/2020, included that resident #1 had fallen at home, hit his head, and was sent to the emergency room via 911. The progress note included [DIAGNOSES REDACTED]. It revealed that resident #1 had cardiac arrhythmias due to his low potassium levels related to his diarrhea. He received Potassium, intravenous fluids, and antibiotics while at the hospital for an acute gastroenteritis and [MEDICAL CONDITION]. Review of hospital orders revealed that resident #1 received a Heart Healthy diet while in the hospital, from 5/05/2020 to 5/12/2020. On 5/12/2020 at 10:45 PM, resident #1 was discharged from the hospital and admitted to the skilled nursing facility for short-term care (STC) therapy and nursing services. [DIAGNOSES REDACTED]. His admission dietary communication slip, dated 5/12/2020, revealed that he was to receive the facility's Therapeutic Lifestyle Changes (TLC) diet. It did not include resident #1's [DIAGNOSES REDACTED]. Resident #1's admission minimum data assessment ((MDS) dated [DATE] validated that he had [DIAGNOSES REDACTED]. He had received insulin injections for the past 7 days during the look back period of 5/13-19/2020. His May 2020 Medication Administration Record [REDACTED]. The insulin was documented given as ordered. On 8/12/2020 at 12:30 PM, during an interview with the facility's dietary manager (DM), she stated that diabetic residents are typically given the facility's therapeutic Consistent Carbohydrate Diet (CCD). She said it had no sugar, just sugar substitutes, and limited carbohydrates. At 1:10 PM she explained that the facility's TLC diet is the facility's version of the hospital's Heart Healthy diet. She said that its not exactly the same, but similar. The DM said that the TLC and CCD therapeutic diets differ in that concentrated sweets are not typically part of the CCD, but are part of the TLC diet. She said for example, the CCD uses artificial sweetener's, diet syrup, diet jelly, 2% milk, no canned fruits, no concentrated sweets, potato wedges instead of mashed potatoes. She said the TLC diet is basically for residents who have heart problems, so fat is reduced in the diet. She used a example of a breakfast menu to compare the two diets: the TLC diet would offer pancakes and in lieu of pancakes, the CCD would offer sausage or protein instead of the carbohydrate filled pancakes. The DM said that these diets can be combined for residents with both heart problems and diabetes. She said nursing is responsible to obtain the resident's diet orders at admission and sends the dietary communication slip to the kitchen. The kitchen then prepares the meals accordingly. The DM said that she did not know for what reason diabetic resident #1 had a TLC diet and no CCD, except that maybe it was what he had received at the hospital. She indicated that the registered dietician (RD) receives a copy of each new resident's dietary slip. The DM said that the RD conducts the initial nutritional evaluation for each resident and makes recommendations for therapeutic diets if changes are needed. Review of resident #1's initial nutritional revealed that the RD did not initiate the initial nutritional evaluation until 5/20/2020, eight days after resident #1 was admitted to the facility. It included the following recommendation: Add Consistent Carbohydrate Diet (CCD) to diet order for [DIAGNOSES REDACTED].#1 was admitted to the facility, his diet changed from the TLC diet to the TLC diet with the CCD. The resident was soon discharged to the hospital on [DATE] after a fall in the facility and did not return. He was in the facility for a total of 17 days. On 8/13/2020 at 4:23 PM, during a phone interview with the RD, she validated that her initial evaluation of resident #1 had not been initiated until 5/20/20 and was not completed until 5/27/2020. The RD said that usually she tried to do them within 3-4 days of admission, but that she had 14 days to complete her evaluations and assessment for the MDS. She did not offer any explanation as to why this evaluation had not been initiated sooner than 8 days post admission. The RD said that when she saw that the resident had a [DIAGNOSES REDACTED]. She indicated that nursing staff or the dietary manager could have caught that he was diabetic and followed through on obtaining a CCD. She said that even when she made a recommendation for a therapeutic CCD, it is individualized to the resident and it is his/her choice as to whether or not the resident wants to follow the recommended diet. She said that the dietary manager conducts a food preference assessment at admission and talks to the residents and/or families about what they want and do not want. The RD said that she had been working remotely from home since about March 2020 due to the COVID-19 pandemic. She said she had access to the facility's electronic medical record program, could see who the new admissions were, and prioritized new admission residents according to their [DIAGNOSES REDACTED]. She said prior to working remotely from home, her days in the facility were on Mondays, Wednesdays and Fridays. The RD that is when she would talk with residents and families about their diets. The RD said that at this time, she does call residents or their families for information. The DON was present during this phone call interview. Continued review of resident #1's medical record revealed that there was no evidence that the DM had conducted a food preference evaluation for resident #1 to determine what he might want. These findings were validated by the director of nursing (DON) on 8/13/2020 at about 4:55 PM. The DON said that she would have expected the admitting nurse to add CCD to resident #1's dietary communication slip because he had a [DIAGNOSES REDACTED]. On 8/13/2020 at 9:30 AM, phone interview with a resident #1 and a family member said that he had been an insulin dependent diabetic for many years. They stated that while at the facility he had wanted to be on a therapeutic diabetic diet to help control his diabetes and blood sugar. The family member said resident #1 was only in the facility about 17 days and most of the time, the foods were higher in carbohydrates, like mashed potatoes and pancakes. Resident #1 said, Yes .mashed potatoes .pancakes. Resident #1 did not recall anyone addressing his concerns.