STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106135	A. BUILDING _____ B. WING _____	**08/20/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DOLPHIN POINTE HEALTH CARE CENTER	**5355 DOLPHIN POINT BLVD JACKSONVILLE, FL 32211**

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 -** Few	**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 a review of resident records and interviews with staff, the facility failed to maintain complete and accurately documented medical records for three (Residents #1, #4 and #5) of three residents reviewed for transfer/discharge, from a total of eight residents in the sample. The findings include: During an interview with the Director of Nursing on 8/20/20 at 2:30 p.m., she stated the floor nurse assigned to any given resident was responsible for completing all transfer paperwork when a resident was sent out to the hospital. When she was asked what forms were completed, she replied, The eInteract form, the Change in Condition form and the Transfer forms should all be completed. Records were requested for Residents #1, #4 and #5 for review. A record review for Resident #1 found she was admitted to the facility on [DATE]. She had a family member designated as her Power of Attorney (POA) for care and financial decisions. Resident #1 had an AHCA (Agency for Health Care Administration) Nursing Home Transfer and Discharge Notice that indicated a transfer to the hospital for shortness of breath, effective 8/6/20. The form noted the date the notice was given to the resident was 8/7/20. The form was incomplete, omitting the following required information: The name, address and phone number of the resident representative, the discharging facility's contact person and phone number, the address and phone number of the receiving hospital, and the physician or his/her designee's name, signature and date. The fields asking for the date notice was given to the resident/legal guardian, the local Long-Term Care Ombudsman and the resident's clinical record were also blank. In the signature block requesting the resident's or representative's name, signature and date, a handwritten explanation stated, unable to obtain signature. (Photocopy Obtained) A record review for Resident #4 found she was admitted to the facility on [DATE]. She was listed as her own responsible party but had two family members as emergency contacts. Resident #4 had an AHCA Nursing Home Transfer and Discharge Notice that documented her transfer to the hospital for a fall, effective 8/10/20. The date the notice was given was 8/11/20. The form was left incomplete, omitting the following information: The name, address and phone number of the resident representative, the discharging facility's contact person and phone number, the address and phone number of the receiving hospital, and the physician or his/her designee's name, signature and date. The fields asking for the date notice was given to the resident/legal guardian, the local Long-Term Care Ombudsman and the resident's clinical record were also blank. In the signature block requesting the resident's or representative's name, signature and date, a handwritten explanation stated, unable to obtain signature. (Photocopy Obtained) A record review for Resident #5 found she was admitted to the facility on [DATE]. An AHCA Nursing Home Transfer and Discharge Notice documented her transfer to the hospital for low oxygen saturation rates, effective 8/15/20. The notice was given 8/17/20. The form was left incomplete, omitting the following information: The name, address and phone number of the resident representative, the discharging facility's contact person and phone number, the address and phone number of the receiving hospital, and the physician or his/her designee's name, signature and date. The fields asking for the date notice was given to the resident/legal guardian, the local Long-Term Care Ombudsman and the resident's clinical record were also blank. In the signature block requesting the resident's or representative's name, signature and date, a handwritten explanation stated, unable to obtain signature. (Photocopy Obtained) An interview was conducted with the Administrator on 8/20/20 at 3:40 p.m. He reviewed the forms for Residents #1, #4 and #5 and acknowledged they were required prior to a transfer or discharge. He confirmed they were incomplete and that multiple fields had been omitted. The Administrator acknowledged the form was not documented to indicate facility efforts to notify the resident's representative of the transfer in the absence of the resident's signature, and that this should be noted on the form. A signature should be obtained as soon as possible. .

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