STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105609	A. BUILDING _____ B. WING _____	**07/30/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NSPIRE HEALTHCARE TAMARAC	**5901 NW 79TH AVENUE TAMARAC, FL 33321**

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 observations, interviews and record review, the facility failed to follow the wound care specialist dressing treatment order for 1 of 2 sampled resident, Resident #1; and failed to provide care and services consistent with professional standards of practice in wound care technique to potentially promote the healing of existing pressure ulcers to the extent possible for 1 of 2 sampled resident, Resident #2. The findings included: Review of the facility's policy and procedure titled Clinical Guideline Skin and Wound effective date 04/01/17 documents .licensed nurse .refer to therapy as indicated .monitor residents' response to treatment and modify treatment as indicated . Review of the facility's Skills Competency Assessment: clean dressing changing documents clean work surface and cover with non-permeable barrier .place gather supplies on prepped work surface and position wastebasket/bag in accessible area for dressing disposal .perform hand hygiene, apply gloves, provide privacy .place a clean barrier under the area to be dressed . 1. Resident #1 was admitted to the facility on [DATE] with a discharge on 07/10/20. The medical record review documented a sacral pressure ulcer wound on initial admission to the facility. Review of the physician orders for wound care were as follow: 05/28/20 documented wound consult. 05/28/20 documented clean area with normal saline, pat dry and cover with dressing to the left buttock every other day 06/03/20 documented cleanse left heel with normal saline solution, pat dry, apply [MEDICATION NAME] solution and cover with ABD pads, wrap with kerlix on Monday, Wednesday and Friday's 06/03/20 documented clean left buttock with normal saline, pat dry, apply Therahoney, cover with dry dressing and secure with tape every other day. 07/04/20 documented clean left buttock with normal saline, pat dry, apply Therahoney, cover with dry dressing and secure with tape every day. Review of Resident #1's Wound Care Specialist initial evaluation, dated 06/11/20, and the weekly follow up management summary from 06/18/20 to 07/09/20 documented a dressing treatment plan for the resident's left buttock wound as Leptospermum Honey (Therahoney) and alginate calcium daily, and a dressing treatment plan for the resident's right heel wound as [MEDICATION NAME] solution daily. Review of the resident's admission assessment, physician orders and Treatment Administration Record (TAR) for June and July 2020 lacked documentation of the resident's right heel wound and treatment. Review of Resident #1's June 2020 TAR documented clean left buttock area with normal saline solution, pat dry. Apply Therahoney, cover with dressing and secure with tape every other day', from 06/04/20 through 06/30/20. The review revealed that the wound care treatment to the resident's left buttock wound was not administered daily as per the wound care specialist dressing plan of treatment dated 06/11/20, 06/18/20 and 06/25/20. Review of the resident's July 2020 TAR documents clean left buttock area with normal saline, pat dry. Apply Therahoney and cover with dressing and secure with tape every other day, through 07/04/20. A new TAR entry dated 07/04/20 documented the same treatment for [REDACTED]. The review revealed the wound care treatment to the resident's left buttock wound was not administered daily as per the wound care specialist dressing plan of treatment dated initially on 06/11/20 and continuing throughout 07/09/20. On 07/28/20 at 3:55 PM, an interview was conducted with the Director of Nursing (DON) and stated that the facility wound care protocol is that the Primary Care Physician orders will be followed until the resident is seen by the Wound Care specialist next time he/she is in the facility. The DON stated that Resident #1 was admitted on a Wednesday and the wound care specialist was already at the facility, but she was seen the following Thursday (06/03/20). The DON was asked to submit the resident's initial wound evaluation by the specialist. On 07/30/20 at 3:37 PM, a telephone call was made to the facility Director of Nursing. The DON was apprised that Resident #1's wound care specialist initial and follow up management summary from 06/11/20 to 07/09/20 documented a dressing treatment plan as Leptospermum Honey (Therahoney) and alginate calcium daily. The DON was apprised that Resident #1's wound care order and treatment were not followed as per the wound care specialist dressing treatment plan. The DON confirmed that Resident #1 sacral wound dressing was done every other day during the month of June instead daily for 30 days as per the wound care specialist initial dressing treatment plan on 06/11/20 and also that alginate calcium was not applied as ordered during the month of June and July 2020 per the wound care specialist dressing treatment plan for June and July 2020. The DON was apprised that the resident's wound consult order was placed on 05/28/20 and the wound care specialist did not evaluate the resident until 06/11/20. The DON stated that the resident was seen on 06/03/20. There was no evidence or record provided of the 06/03/20 physician evaluation during the survey, or on 07/30/20. The DON was apprised that the wound care specialist summary for 06/11/20 documented Initial Wound Evaluation and Management Summary. Further review of the documentation revealed that both wounds had improved. 2. Resident #2 was admitted to the facility on [DATE] with a re-admission on 03/15/18. Review of the medical record documented a [DIAGNOSES REDACTED]. Review of the physician orders dated 07/06/20 documented apply Therahoney to sacral pressure ulcer and alginate calcium: cleanse with normal saline, apply skin prep to periwound then apply Therahoney to wound bed and cover with border dressing daily. On 07/28/20 at 11:35 AM, an interview was conducted with Staff A, a Licensed Practical Nurse (LPN), who stated she is the dedicated wound care nurse for the facility. Staff A stated that Resident #1 has a sacral wound and is receiving daily wound care and confirmed the physician orders for wound care. On 07/28/20 at 12:35 PM, observation of wound care for Resident #2, was performed by Staff A, and assisted by Staff B, a Certified Nursing Assistant. The observation revealed Staff A obtained a vial of normal saline solution, four sterile packages of gauze sponges, two skin prep pads, a pair of scissors, a red bag, three calcium alginate dressing pad, silicone border dressing and a tube of Therahoney which she poured into a medication cup. Observation revealed Staff A entered Resident #2's room with the supplies on a foam tray and without cleaning the over-the-bed table or placing a barrier, she placed the foam tray on the over-the-bed table and proceeded to the bathroom to perform hand washing. Observation revealed Staff A performed handwashing and retrieved a paper towel from the holder by touching the paper towel handle with her right-hand thumb to obtain paper towel. Staff A performed this action three times and did not perform hand hygiene after touching the handle, which is considered contaminated. Consequently, observation also revealed Staff B performed handwashing and retrieved a paper towel from the holder by touching the paper towel handle with the back of his right-hand to obtain the paper towel and did not perform hand hygiene after touching the handle, which is considered contaminated. Staff A then proceeded to don gloves, removed the resident's foley drainage bag from the privacy sleeve and placed the drainage bag on top of the bed, reached the bed remote control, repositioned the resident in a flat position, turned the resident over on her left side, placed the biohazard bag on top of the bed and removed the sacral wound dressing, dated 07/27/20. Staff A removed her gloves, performed handwashing and retrieved a paper towel from the holder by touching the paper towel handle with her right-hand thumb to obtain paper towel. Staff A performed this action again three times and did not perform hand hygiene after touching the handle. Observation revealed Staff B allowed the resident to move unto her back, and upon the undressed wound on a soiled brief. Staff A proceeded to open up one sterile gauze sponge package, leave the gauze inside the packaging, opened another gauze package and placed it on top of the sterile gauze with the gauze touching the outer side of the packaging. Staff A then opened one calcium alginate dressing package and the allowed the calcium alginate to touch the contaminated medication cup. Staff A opened up two more calcium alginate packages and placed them on top of uncleaned table, donned gloves, and cleaned the two sites of the sacral wound with one gauze. Staff A, without changing gloves, reached to the bed table, retrieved the

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105609	A. BUILDING _____ B. WING _____	**07/30/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NSPIRE HEALTHCARE TAMARAC	**5901 NW 79TH AVENUE TAMARAC, FL 33321**

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	(continued... from page 1) medication cup and poured the Therahoney over two of the calcium alginate dressings. Staff A dropped the contaminated medication cup on top of one of the calcium alginate dressing. Without drying the wound after cleaning it with saline solution, Staff A placed the contaminated calcium alginate dressing over the resident's wound bed. Without applying the skin prep as ordered, she placed a silicone dry dressing over the wound. The resident's dressing was applied off on the right side and Staff A stated that it is her skin, it does that all the time. Observation revealed Staff B removed his gloves, performed hand washing for 10 seconds and retrieved a paper towel from the holder by touching the paper towel handle with his right-hand knuckles to obtain paper towel. Staff B performed this action two times and did not perform hand hygiene after touching the contaminated handle. On 07/28/20 at 1:25 PM, during an interview with Staff A, the wound care observation findings were discussed. Staff A confirmed the findings. On 07/28/20 at 1:30 PM, an interview was conducted with Staff B and he stated that he does hand scrubbing for 10 seconds and 20-30 seconds rinsing under the water. Staff B stated that water takes the germ out of the hands. On 07/28/20 at 4:05 PM, during an interview, the Director of Nursing (DON) was apprised about the wound care observations findings, of Staff A's wound care technique and cross contamination for Resident #2. She was informed about Staff A and Staff B failed to perform proper handwashing to prevent cross contamination to the wound.