STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105399	A. BUILDING _____ B. WING _____	**03/04/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SEA BREEZE REHAB AND NURSING CENTER	**3663 15TH AVE VERO BEACH, FL 32960**

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 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure timely care and services were provided for 2 of 5 sampled residents. The nurses failed to ensure Resident #1 received ordered medications including an intravenous (IV) antibiotic in a timely manner, upon admission to the facility from the hospital. The nurses also failed to ensure Resident #2 was provided wound care in a timely manner, upon admission to the facility. The findings included: 1. Review of the record revealed Resident #1 was admitted to the facility on [DATE] at approximately 2 PM. Discharge orders from the hospital included the IV (intravenous) antibiotic [MEDICATION NAME] 3.375 grams (gm) to be administered every 8 hours at midnight, 8 AM, and 4 PM. The last documented dose administered at the hospital was on 02/26/20 at 9 AM. Hospital orders also included the medication [MEDICATION NAME] (a pain medication) to be administered twice daily. Review of the facility orders revealed the following: 02/26/20, [MEDICATION NAME] ([MEDICATION NAME]) 3.375 gm IV every 8 hours for pneumonia for 7 days. This order was clarified on 02/28/20 to include the reason for administration to be ESBL (Extended spectrum beta-lactamases/a bacterial infection). 02/26/20, May administer evening medication when arrived from pharmacy on 11 PM to 7 AM shift. 02/26/20, Pregabalin Capsule ([MEDICATION NAME]) 100 milligrams (mg) twice daily by mouth for [MEDICAL CONDITION] (pain). Review of the Medication Administration Record [REDACTED]. This MAR indicated [REDACTED]. Review of the corresponding progress notes documented by Staff A, a Licensed Practical Nurse (LPN), revealed these two medication were on order from the pharmacy. During an interview on 03/04/20 at 12:10 PM, Staff B, the LPN who completed the admission for Resident #1, was asked about the process for obtaining medications for residents who are newly admitted to the facility. Staff B explained they get a copy of medications from the hospital, and confirm the discharge medications from the hospital with the resident's physician at the facility. The LPN stated the medications are then put into the computer. When asked specifically about IV antibiotics, the LPN explained they have a new Pyxis system (an automated medication dispensing system) that they started using 2 or 3 weeks earlier, and before that time they had three E-kits (emergency kits) with medications. During an interview on 03/04/20 at 12:20 PM, Staff A, the LPN for Resident #1 who worked 02/26/20 from 3 PM to 11 PM, explained she was fairly new to the facility, and when she has an admission her supervisor would put the medication orders in the computer. When asked about IV antibiotics, the LPN stated she would call the pharmacy to see if they can be delivered ASAP (as soon as possible). If they can not obtain the medications quickly, the LPN stated she would call the physician and get permission to give them as soon as they were delivered. When asked, the LPN stated there was not a stock for IV medications, and did not believe there were any in the Cubix (the brand of automated medication dispensing system used at this facility). The LPN confirmed the reason she did not administer the [MEDICATION NAME] for Resident #1 was because it was not at the facility. During a subsequent interview on 03/04/20 at 1:35 PM, Staff A was asked about the [MEDICATION NAME] order for Resident #1. The LPN explained the order was for a capsule, and they did not have capsules at the facility. The Assistant Director of Nursing (ADON) was asked to locate and provide the inventory lists for any E-kits and for their automated dispensing system. Review of the Polaris PRX1 . Inventor on Hand list provided by the ADON, who stated this list was for their system, revealed a supply of [MEDICATION NAME] 3.375 IV and Pregabalin ([MEDICATION NAME]) 50 mg capsules was available for immediate use. The ADON agreed the two medications were available for administration to Resident #1 upon admission. 2. Review of the record revealed Resident #2 was admitted to the facility on [DATE] at approximately 7:00 PM. Review of the hospital discharge paperwork documented Resident #2 had a right abdominal incision with incisional dehiscence (opening) with a wound VAC (a negative pressure dressing). Review of the facility record revealed an Admission Readmission Nursing Packet dated 02/21/20 at 6:53 PM that documented the presence of a front right iliac crest draining wound on the resident's abdomen. Review of the admission orders [REDACTED]. Further review of the record revealed a skin check completed on 0[DATE] at 12:52 PM that revealed a 10 cm scar with an area of dehiscence 0.7 centimeters (cm) by 0.6 cm by and 0.8 cm deep tunnel, with moderate drainage. Review of the facility orders and corresponding administration record revealed the following: 02/21/20, admit to the facility 02/23/20, Cleanse wound to abdomen with normal saline, pat dry and apply dry dressing daily. This order was input into the computer on 02/23/20 at 10:12 PM to start on 0[DATE] during the day shift. The treatement / medicaiton administration records lacked any documented administration. 0[DATE], Cleanse wound to abdomen with normal saline, skin prep to peri-wound, lightly pack opening with small strip of silver alginate and cover with a clean dry dressing, Change daily. This order was input into the computer on 0[DATE] at 1:19 PM to start on 02/25/20 during the evening shift. The treatment /medication administration records documented the wound care started on 02/25/20 during the evening shift. During an interview on 03/04/20 at 3:06 PM, the Wound Care Nurse explained the direct care nurses are responsible for the daily wound care and the initial skin / wound assessment. The Wound Care Nurse stated she will do wound care as time permits. The Wound Care Nurse explained she will do a follow up wound assessment the next time she is in the building after an admission, explaining she works Monday through Friday. She stated in general, the admission nurse should get the initial orders for care. Review of the record with the Wound Care Nurse confirmed the lack of wound care orders until 0[DATE], or the provision of wound care from the admission of Resident #2 on 02/21/20, until the first documented wound care on 02/25/20 during the evening shift.

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