STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105882	A. BUILDING _____ B. WING _____	**06/16/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WINKLER COURT	**3250 WINKLER AVENUE EXTENSION FORT MYERS, FL 33916**

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 0604 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interview, the facility failed to obtain a physician order and accurately assess 1 resident (Resident #998) of 1 resident sampled for use of a restraint. This has the potential to cause anxiety, agitation and negatively affect the resident's quality of life. The findings included: The facility policy Restraint Management, dated May 2020, indicated restraints will be used only when necessary to treat a medical symptom and not used for staff convenience. The least restrictive restraint, for the shortest duration of time will be applied to assist the resident in reaching their highest level of physical and psychosocial well-being. The facility will demonstrate and document the presence of specific medical symptom(s) that require the use of the restraint to treat the cause of the symptom. Restraints include . Lap cushions, lap trays or safety belts the resident cannot remove. The guidelines instructed staff to obtain a physician's order for a restraint, including medical symptoms requiring restraint use, type of restraint, and duration of use. On 8/10/20 at 5:25 a.m., Resident #998 was observed sitting in a wheelchair in front of the nursing station on the Memory Care Unit. The resident had a lap buddy in place across her trunk and hooked onto the wheelchair. Resident #998 was trying to remove the lap buddy. The resident was observed for 15 minutes attempting to remove the lap buddy but was not able to remove it. Resident #998 was restless and had a worried look. The resident was not interviewable and did not respond to questions. On 8/10/20 at 5:40 a.m., in an interview, Licensed Practical Nurse Staff K said she placed the lap buddy on Resident #998 to keep her from getting up and falling. On 8/10/20 at 8:30 a.m., review of clinical record for Resident #998 revealed the resident was [AGE] years old with a [DIAGNOSES REDACTED]. The clinical record contained a Minimum Data Set (MDS) (clinical assessment of a resident) dated 7/29/20 which documented the resident had no restraints and used no mobility devices including a wheelchair. The MDS documented the resident had a Brief Interview for Mental Status (a test for cognitive function) Score of 3, indicating she had severe cognitive impairment. Review of the clinical record contained no documentation of an assessment for the use of a restrictive device/lap buddy. No physician order for [REDACTED]. The DON confirmed Resident #998 did not have an assessment or physician order for [REDACTED].
F 0659 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care by qualified persons according to each resident's written plan of care.** Based on record review and staff interview the facility failed to have documentation for 1 (Staff Z) of 2 staff reviewed had the required education and training to administer intravenous therapy via central lines for 1 (Resident #991) of 2 sampled residents reviewed receiving intravenous medications. The findings included: Review of the Nurse Practice Act 64B9-12.005 Competency and Knowledge Requirements Necessary to Qualify the LPN (Licensed Practical Nurse) to Administer IV (Intravenous) Therapy. showed (2) Central Lines. The Board recognizes that through appropriate education and training, a Licensed Practical Nurse is capable of performing intravenous therapy via central lines under the direction of a registered professional nurse as defined in subsection 64B9-12.002(2), F.A.C. Appropriate education and training requires a minimum of four (4) hours of instruction. The requisite four (4) hours of instruction may be included as part of the thirty (30) hours required for intravenous therapy education specified in subsection (4) of this rule. The education and training required in this subsection shall include, at a minimum, didactic and clinical practicum instruction in the following areas: (a) Central venous anatomy and physiology; (b) CVL (Central Venous Line) site assessment; (c) CVL dressing and cap changes; (d) CVL flushing; (e) CVL medication and fluid administration; (f) CVL blood drawing; and (g) CVL complications and remedial measures. Upon completion of the intravenous therapy training via central lines, the Licensed Practical Nurse shall be assessed on both theoretical knowledge and practice, as well as clinical practice and competence. The clinical practice assessment must be witnesses by a Registered Nurse who shall file a proficiency statement regarding the Licensed Practical Nurse's ability to perform intravenous therapy via central lines. The proficiency statement shall be kept in the Licensed Practical Nurse's personnel file. On 8/11/20 at 7:50 a.m., an observation revealed Resident #991 had an intravenous line in place to the right arm. Review of the clinical record revealed Resident #991 was receiving Intravenous (IV) antibiotics through a Peripherally Inserted Central Catheter (PICC) to the right arm. Review of the electronic clinical record revealed on 7/17/20, 7/20/20, 7/24/20 and 8/6/20 Licensed Practical Nurse (LPN) Staff Z signed off on the Medication Administration Record [REDACTED]. LPN Staff Z also placed her initials on the MAR indicated [REDACTED]. On 8/11/20 at 4:35 p.m., in an interview the Staff Educator verified LPN Staff Z had been administering IV therapy through a central line to Resident #991.
F 0757 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview the facility failed to withhold laxatives according to the physician's orders for 1 (Resident #1) of 1 resident sampled for experiencing loose stools. The staff administered [MEDICATION NAME] and Senna-S when contraindicated. The findings included: Review of the clinical record for Resident #1 revealed the physician's orders for 6/2020 included [MEDICATION NAME] solution (a laxative) 30 milliliters by mouth at bedtime. The order specified to hold if loose stool. The physician's orders also included Senna-S (a laxative) 8.6-50 milligrams (mg) to be administered at bedtime for constipation. The American Herbal Products Association recommends that senna products be labeled, Do not use this product if you have abdominal pain or diarrhea . Discontinue use in the event of diarrhea or watery stools. (source: https://www.webmd.com/vitamins/ai/ingredientmono-652/senna) Review of the clinical notes showed: On 5/30/20 the Certified Nursing Assistant (CNA) reported Resident #1 had diarrhea. The nurse noted a temperature of 100 degrees Fahrenheit. On 6/2/20 a general progress note documented Resident #1 complaining of diarrhea for 2 days. On 6/4/20 the Advanced Nurse Practitioner (ARNP) documented Resident #1 complained of having watery diarrhea: worse On 6/5/20 Resident #1 had a stool culture positive for [MEDICAL CONDITION], a bacterium that causes diarrhea and [MEDICAL CONDITION] (inflammation of the colon). Review of the daily CNA documentation revealed from 6/1/20 through 6/14/20 the consistency of Resident #1's bowel movements were loose/diarrhea. Review of the Medication Administration Record (MAR) for 6/2020 showed the licensed nurses administered the Senna-S and [MEDICATION NAME] solution every day at 9:00 p.m., even though Resident #1 was having loose stools and diarrhea During an interview on 6/15/20 at 3:40 p.m., the ARNP said Resident #1 should not be taking any laxatives. She said, Of course not. She shouldn't be taking any laxatives. It wouldn't help with her diarrhea. The ARNP said she would discontinue the order for [MEDICATION NAME] and Senna-S. On 6/15/20 at 5:45 p.m., during an interview the Director of Nursing (DON) verified the laxatives were documented as administered on the MAR. She said the ARNP should have discontinued the [MEDICATION NAME] and the Senna-S. The DON added, some nurses just look at the MAR and follow physician orders.
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.**

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
	105882	A. BUILDING _____ B. WING _____	06/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WINKLER COURT	3250 WINKLER AVENUE EXTENSION FORT MYERS, FL 33916

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	(continued... from page 1) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of facility's policies and procedures, clinical record review, and staff interview the facility failed to maintain complete and accurate records related to midline catheters for 2 (Resident #1 and #2) of 3 residents reviewed. A midline catheter is an intravenous catheter approximately 8 to 12 centimeters inserted in the upper arm with the tip located just below the axilla (midline to the heart). Accurate records were necessary to document the course of a resident's care provided by the facility. The facility also failed to document medications that were given or to document why they were not given. The findings included: 1. Review of the facility's policy and procedure Section 6.2 Assessment, Documentation and Complications (dated 8/16) specified the purpose is: To assure safe continuum of care for the resident receiving infusion therapy and to provide a legal document verifying proper care of the resident receiving infusion therapy . 1. Document initial and ongoing assessments and interventions, . 4. Documentation should include: Informed consent if appropriate. Assessment of site and surrounding tissue for complications. Condition of dressing. Any treatment done to catheter or site . The facility's policy and procedure Section 5.16 Infusion Therapy Procedures (dated 8/16) specified to change a midline dressing every 48 hours if gauze dressing or every 7 days if transparent membrane dressing. 2. On 6/16/20 at 11:00 a.m., review of the Resident #1's clinical record showed on 6/7/20 a midline catheter was inserted to the resident's right arm to infuse intravenous antibiotics. Review of the nurses' notes and the Medication Administration Record (MAR) failed to show documentation of an assessment of the site or and surrounding tissue or dressing changes from 6/9/20 through 6/16/20. On 6/16/20 at 11:35 a.m., during a side by side review of the MAR and the nurses' notes, the Director of Nursing verified the lack of documentation. She said the dressing should be changed every 7 days. She said, They will do it today. 3. The physician's orders [REDACTED]. The MAR lacked evidence the resident received these in the morning of 6/8/20. There was no documentation of reason for not administering the medications. The Treatment Record for 6/2020 lacked evidence the nurse applied [MEDICATION NAME] cream to the resident's coccyx as for irritation during the evening shift on 6/13/20. 4. Resident #2 was re-admitted to the facility on [DATE] with a midline catheter and was receiving antibiotics to treat a urinary tract infection. Review of the clinical record documented Resident #2 had received [MEDICATION NAME] sodium (an antibiotic to treat infections) daily 6/11/20 through 6/18/20. The record contained no documentation the midline dressing was changed, or an assessment of the midline catheter had been completed to monitor the site for sign or symptoms of infection. On 6/16/20 at 1:40 p.m., in an interview the Director of Nursing confirmed there was no documentation Resident #2's midline catheter site was monitored or care of the site provided since admission on 6/10/20.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** Based on observation, interview, and record review the facility failed to follow laundry handling procedures, basic sanitation, and current infection control COVID-19 recommendations by Centers for Disease Control and Prevention (CDC). The findings included: 1. On 6/15/20 at 9:15 a.m., during an initial tour of the clean side of the laundry room, there were two racks containing residents' clean laundry. There were two carts resting against the clean clothing hanging from the racks and overflowing to the floor with clean laundry. In an interview on 6/15/20 at 9:20 a.m., the Maintenance Director confirmed the clean resident laundry was touching the floor. Photographic evidence obtained 2. On 6/15/20 at 9:15 a.m., during an initial tour of the of the laundry room, on the soiled section of the laundry room, the sink designated as the eye wash station, was covered with brown, rust colored grime and debris in the sink. The faucet of the eye wash sink had rust and grime at the base of each handle. There was a rusted spatula on the left side of the faucet. On the right side there was a dusty spray nozzle. The red caps covering the emergency eye wash jets, had a thick layer of dust and grime. There was a rusted, metal rack next to the next to the eye wash station and on the top shelf were two protective face shields. The face shields were dusty and covered with grime. There was a mop head and a pair of gloves, resting on the face shields. In an interview on 6/15/20 at 9:20 a.m., the Maintenance Director confirmed the condition of the eye wash station and said he did not know who was responsible to clean the eye wash station. Photographic evidence obtained 3. CDC Preparing for COVID-19 in Nursing Homes guidance includes: Implement Source Control Measures. * HCP should wear a facemask at all times while they are in the facility . Refer to: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html CDC Using Personal Protective Equipment (PPE) guidance includes: Respirator/facemask should be extended under chin. Both your mouth and nose should be protected. Refer to: https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html On 6/15/20 at 9:22 a.m., during observation on the Edison unit, Registered Nurse (RN), Staff D was working at the medication cart, located in the hall and her face mask was worn under her chin, exposing her mouth and nose. RN Staff D confirmed the mask was not worn properly. On 6/15/20 at 9:45 a.m., during an observation of the Memory Care Unit, RN Staff E was seated at the nurse's station and her cloth face mask was on her chin, exposing her mouth and nose. On 6/15/20 at 10:05 a.m., RN Staff D was observed walking in the hallway of the Edison Unit with her face mask positioned only over her mouth and chin, exposing her nose. In an interview on 6/15/20 at 10:25 a.m., the RN Infection Preventionist said the staff were required to wear a surgical mask when in the building and if they used a cloth mask, they were to wear a surgical mask under it. The RN Infection Preventionist said all staff including agency staff were educated on the facility policy regarding the use of face masks and personal protective equipment (PPE). She said the staff assigned to work on the Memory Care Unit were instructed to social distance residents six feet apart and encourage them to wear a face mask. The Infection Preventionist said the facility followed the Centers for Disease Control guidelines as their policy for COVID-19. On 6/15/20 at 2:00 p.m., the RN Infection Preventionist and Certified Nursing Assistant (CNA) Staff F were observed walking shoulder to shoulder down the hallway from the(NAME)Unit. CNA Staff F was not wearing a face mask when speaking with the RN Infection Preventionist. CNA Staff F said, I'm off the clock now, I don't need to wear it now, I'm leaving the building. In an interview on 6/15/20 at 2:02 p.m., the RN Infection Preventionist confirmed a face mask was always required to be worn when in the building and by all staff. 4. CDC Infection Prevention and Control (IPC) Guidance for Memory Care Units guidance includes: Limit the number of residents or space residents at least 6 feet apart as much as feasible when in a common area, and gently redirect residents who are ambulatory and are in close proximity to other residents or personnel . Refer to: https://www.cdc.gov/coronavirus/2019-ncov/hcp/memory-care.html On 6/15/20 at 9:35 a.m., during initial observation on the Memory Care Unit, 4 residents sat shoulder to shoulder in chairs in front of the nursing station. The residents were not wearing face masks and not seated six feet apart. The nurse and two CNAs observed the residents but made no attempt to space the residents to maintain social distancing and did not encourage the residents to apply a face mask. In an interview on 6/15/20 at 9:46 a.m., RN Staff E said the residents were to wear face masks, but it was difficult to keep them on. Staff E said each resident had their own masks that were kept in the resident rooms. In an interview on 6/15/20 at 10:25 a.m., the RN Infection Preventionist said the staff assigned to work on the Memory Care Unit were instructed to social distance residents six feet apart and encourage them to wear a face mask. 5. CDC Preparing for COVID-19 in Nursing Homes, Core Practices guidance includes: Educate and train HCP, including facility-based and consultant personnel (e.g., wound care, podiatry, barber) and volunteers who provide care or services in the facility . - Reinforce adherence to standard IPC (infection prevention and control) measures including hand hygiene. Refer to: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html Observations on 6/15/20 at 9:50 a.m., CNA Staff A was working on the Memory Care Unit. Staff A was leaving a resident's room, carrying a meal tray and placed it in the meal cart located in the hallway. CNA Staff A did not perform hand hygiene and removed a different meal tray from the cart. Staff A entered a different resident room and was observed assisting the resident with the meal. CNA Staff A did not perform hand hygiene prior to assisting the resident.