STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106002	A. BUILDING _____ B. WING _____	**10/18/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WEDGEWOOD HEALTHCARE CENTER	**1010 CARPENTERS WAY LAKELAND, FL 33809**

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 0554 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Allow residents to self-administer drugs if determined clinically appropriate.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to evaluate a resident for self-administration of medications related to nebulizer treatments for one resident (#14) of 4 residents who receive nebulizer treatments. Findings included: Resident #14 was admitted on [DATE]. Review of her [DIAGNOSES REDACTED]. Review of the admission Minimum Data Set ((MDS) dated [DATE] showed a Brief Interview for Mental Status (BIMS) score of 15 (cognitively intact). Section G, Functional Status showed she required extensive assistance for bed mobility and transfers and was dependent for toileting. Section O, Special Treatments, showed she was on oxygen. Review of the Physician order [REDACTED]. Review of the care plan for the [DIAGNOSES REDACTED]. Monitor / document side effects and effectiveness as of 10/08/20. Educate resident / resident representative regarding side effects and overuse of inhalers and nebulizers. Observation on 10/16/20 at 7:55 p.m. Resident #14 was lying in her bed holding her nebulizer mask. It had unplugged from the machine. She pushed her call light and Staff A, RN, Supervisor entered and re-plugged it into the nebulizer. The resident was alone during the nebulizer treatment. Observation on 10/16/20 at 12:40 a.m. revealed Staff I, Licensed Practical Nurse (LPN) entering Resident #14's room. Staff I, LPN had received the pulse oximeter from Staff G, CNA and placed it into her pocket. Without cleaning the pulse oximeter Staff I, LPN placed the pulse ox Resident #14's finger. She stated her oxygen saturation was at 99%. The resident stated that she had phlegm in her throat. Staff I, LPN reminded her the resident she had been positive for COVID-19 just three months ago. The nurse stated that her oxygen saturation was okay. The resident's head of bed was elevated. She had her nebulizer mask on her face. Staff I, LPN took the nebulizer mask from the resident at 12:42 a.m. and placed it into the bag. She then washed her hands. There was not a nurse with the resident during her nebulizer treatment. Observation on 10/18/20 at 9:25 a.m. Resident #14 was sitting in her wheelchair at the bedside. She was dressed for the day and reading a book. She had her oxygen via nasal cannula in her nose and the tubing was on the floor. The oxygen was at 3 liters per minute. The nebulizer mask was in the top drawer of her bedside table and was not in a bag. She stated that she does her own nebulizer treatments. The nurse brings in the medicine and puts it in the nebulizer and leaves. The nurse will come back when she calls her. She uses her call light and they check on her. She gets her nebulizer treatments at least daily and sometimes twice a day. She stated that she has the treatments for her shortness of breath. She asks for it when she needs it. Staff J, ADON verified the nebulizer mask was in the drawer, not in a bag. She stated that the nebulizer mask was to be in a bag. She was observed placing the nebulizer mask into a bag without gloves (she had hand sanitized before entering room). She left the room without hand hygiene. On interview it was requested she show the surveyor the assessment that the resident was able to self-medicate. She stated that she could not show it because they do not have residents self-medicate in the facility. We re-entered the room and the resident stated again that the nurse puts the medication in the nebulizer and leaves and comes back later. The ADON just shook her head. Staff J, ADON was standing at the nursing station during the interview and a nurse asked her to sign a paper, she did. When asked about when hand sanitizing was needed, she stated that she had hand sanitized before she went in the room. What about post, she did not say anything and sanitized her hands. During an interview on 10/18/20 at 3:30 p.m. Staff A, RN, Supervisor verified that Resident #14 had two orders for [MEDICATION NAME]-[MEDICATION NAME] 0.5-2.5 every 6 hours as needed for shortness of breath. She also verified that per documentation on the Medication Administration Review (MAR) there was only documentation for one nebulizer administration on 10/16 at 12:51 a.m. instead of 2 as was observed by the surveyor. She stated she did not know why the nurse did not document she had given the resident the nebulizer treatments twice. She also stated she was going to fix the duplicate order and discontinue one. She stated she would educate the staff regarding staying with the resident during their nebulizer treatments. Review of the facility's policy, Nebulizer, revised on 03/20/2018 showed to evaluate the resident and establish a baseline respiratory rate, pulse, oxygen saturation and breathe sounds .instruct the resident to take slow deep breathes and exhale slowly. Administer treatment until medication is deleted; evaluate the resident's response and effectiveness of treatment by evaluating breath sounds, pulse rate, oxygen saturation and respiratory rate. Disassemble and rinse. Place entire unit in a bag to be maintained in the resident's room. Perform hand hygiene. Document treatment in the resident's medical record. Review of the facility's policy, Self-Administration of Medication at bedside, revised on 08/22/2017 showed the resident may request to keep medications at bedside for self-administration in accordance with Resident Rights. Criteria must be met to determine if a resident is both mentally and physically capable of self-administering medication and to keep accurate documentation of these actions. Verify physician's orders [REDACTED]. Complete Self-Administration Medication Evaluation. The Interdisciplinary Team will review the evaluation and will document Section III. Approval granted must be checked yes or no. Complete the Care Plan for approved self-administered drugs. The MAR must identify meds that are self-administered, and the medication nurse will need to follow up with resident as to documentation and storage of medication during each med pass.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to provide necessary care services to assist a dependent resident with incontinence care for 1 (Resident #2) of 3 residents sampled for Activities of Daily Living (ADL). Findings included: A review of Resident #2's medical record revealed that Resident #4 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of Resident #2's Care Plan revealed that Resident #4 was incontinent of bowel and bladder with interventions to provide incontinence care after each episode, check as required for incontinence, and change clothing as needed after incontinent episodes. A review of Resident #2's Minimum Data Set (MDS) Assessment revealed, under the section G - Functional Status, that Resident #4 required Extensive Assistance of one staff member for toilet use and personal hygiene. Resident #2's MDS Assessment also revealed, under section H - Bladder and Bowel, that Resident #4 was always incontinent of bowel and bladder. An interview was conducted on 10/18/2020 at 12:50 PM with the facility's Nursing Home Administrator (NHA), the facility's Risk Manager, and the Regional Director of Clinical Services. The Risk Manager stated that an incident occured on 09/30/2020 involving Resident #2 being video recorded by Staff T, Licensed Practical Nurse (LPN). The Risk Manager stated that Staff T, LPN instructed Staff U, Certified Nurse's Aide (CNA) to give another resident a shower around 06:00 PM on 09/30/2020. While Staff U, CNA was in the hallway getting clean towels for the other resident, she noticed a foul odor coming from Resident #2's room. Staff U, CNA entered Resident #2's room and discovered that Resident #2 was incontinent of bowel and had feces on her right hand. Staff U, CNA then cleaned Resident #2's hand and covered her with a blanket before exiting the room. Staff U, CNA was going to attend to Resident #2's incontinence needs after showering the other resident, according to the interview conducted with the Risk Manager. While Staff U, CNA showered the other resident, Staff T, LPN entered Resident #2's room and recorded the resident on her personal cell phone. Staff T,

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

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F 0684 **Level of harm** - 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** in accordance with professional standards of practice for one (1) of 16 sampled residents (#8) Resident #8 was left alone in his room during a respiratory crisis resulting in him becoming unresponsive and requiring Cardiopulmonary Resuscitation (CPR) from Emergency Medical Services (EMS) and transport to the hospital where he later expired. Findings included: Resident #8 was admitted on [DATE] and discharged to the hospital on [DATE]. Review of the admission showed [DIAGNOSES REDACTED]. An Admission Assessment was not found in the medical record. The Inpatient Discharge Instructions from the Hospital dated [DATE] at 5:06 p.m. showed his blood pressure was ,[DATE], pulse 95 and respirations 16. He was to receive the following medications tonight: Pantoprazole 40 mg oral delated release tablet twice a day for GERD; Carvedilol 6.25 mg twice a day for hypertension; [MEDICATION NAME] 30 mg twice a day for hypertension; [MEDICATION NAME] 3.75 mg at 4 p.m. for [MEDICAL CONDITION]. The Physician order [REDACTED]. Resident was a Full Code. Review of the POS [REDACTED]. [MEDICATION NAME]-[MEDICATION NAME] Solution 0XXX,[DATE].5 (3) mg / 3 ml inhale orally via nebulizer every 4 hours for shortness of breath with a start date of [DATE] at 1:40 a.m. Two nebulizer treatments were given on [DATE] one at 1:40 a.m. and one at 5:00 a.m. by Staff K, LPN. The MAR indicated [REDACTED]. Review of the Nursing Notes showed there was no documentation regarding the resident from the ,[DATE] shift, at the time of admission. Documentation does not start until 1:50 a.m. on ,[DATE], he had been in the building during the ,[DATE] shift. On ,[DATE] at 1:50 a.m. showed the resident was exhibiting rapid respirations with use of his accessory muscles as well as mouth breathing. He stated that he was feeling a bit short of breath. The head of the bed was elevated. He was instructed to purse lip breath. His Oxygen saturation was at 78% on room air. The resident was placed on oxygen at 2 liters per minute via nasal cannula. His oxygen saturation improved to 84%. The physician was notified and a new order to give [MEDICATION NAME] now and every 4 hours was given. Also, to increase the oxygen to ,[DATE] liters per minute to improve his oxygen saturation. Staff K, LPN On ,[DATE] at 2:00 a.m. after his first administration of [MEDICATION NAME] his oxygen saturation improved to 89 to 90%. His respiration rate slowed down. The resident continues with mouth breathing. He was encouraged to breath in through his nose and out through his mouth. He stated he felt better. Will continue to monitor. Staff K, LPN On ,[DATE] at 9:25 a.m. at approximately 9:25 a.m. this writer, Registered Nurse (RN) Assistant Director of Nursing (ADON) was advised that the resident appeared lethargic and was having difficulty breathing by a Staff D, Certified Nursing Assistant (CNA). Staff J, RN immediately took vital signs and the resident's oxygen saturation was at 72% on 3 liters of oxygen. His respirations were between 25 and 30. He had wet chest sounds bilaterally. His blood pressure was ,[DATE]. His temperature was 97.5. The writer, the ADON, immediately called 911 (EMS) and started chest compressions (on interview EMS started chest compressions). 911 (EMS) left immediately doing CPR. Staff J, RN, ADON On ,[DATE] at 9:34 a.m. when received report from ,[DATE] nurse (Staff K, LPN) she stated that the resident was on 3 liters of oxygen to keep his oxygen saturation level up. This ,[DATE] nurse was notified, call doctor. Staff D, CNA stated that she had fed himself on nightshift and was worried because the resident needed assistance with breakfast. Nurse went into room; nurse noticed the resident was lethargic with shortness of breath. Resident was sitting up with eyes open. His blood pressure was ,[DATE], his oxygen saturation was 72% on 3liters of oxygen. 911 (EMS) was called per doctor's order for abnormal vitals. The resident's wife was notified that her husband was being sent out via 911 stretcher. Staff L, LPN On ,[DATE] at 9:45 a.m. the Nursing Home Administrator, physician and family were notified at approximately 9:45 a.m. Staff J, RN, ADON On ,[DATE] at 9:45 a.m. Resident at hospital. Staff J, RN Review of the Change in Condition dated [DATE] at 9:14 a.m. showed Resident #8's change in condition was oxygen saturation at 72% on oxygen at 3 liters per minute. His blood pressure was ,[DATE], pules 53, respirations 25, temperature 97.2. This change started on [DATE]. Resident had abnormal lung sounds and shortness of breath as well as [MEDICAL CONDITION]. The resident had altered level of consciousness. He was a full code. The physician was notified on [DATE] at 9:15 a.m. He was sent out via EMS. His family was called on [DATE] at 9:26 a.m. Signed and dated by Staff L, Licensed Practical Nurse (LPN) Record review of the Weights and Vitals Summary showed: Blood Pressure: [DATE] at 9:16 a.m. ,[DATE] Blood Pressure: [DATE] at 8:14 a.m. ,[DATE] Pulse: [DATE] at 9:16 a.m. 53 Pulse: [DATE] at 8:14 a.m. 88 Respirations: [DATE] at 9:16 a.m. 25 Respirations: [DATE] at 8:14 a.m. 24 During an interview on [DATE] at 11:16 p.m. Staff D, Certified Nursing Assistant (CNA) stated that Resident #8 came in at about 5:30 p.m. on ,[DATE]. She stated he ate dinner just fine. He was not on oxygen when he came from the hospital. The nurse said he did not have orders for oxygen and to throw the oxygen tubing away. She stated that she was back to work the ,[DATE] shift on ,[DATE]. She passed the breakfast trays and had to assist him with eating. She stated that she did not notice any breathing issues at that time. She stated that the ADON came into the building and asked her if anyone needed looking at. The ADON went in to look at him. Staff D, CNA stated that she had two residents across the hall screaming and she went to check on them. She was making sure they had not fallen or something. She stated that she did not hear a Code Blue called. The ADON left the room to call 911. She stated, she guessed nobody was in the room with him. She stated that she had told the hall nurse that she had to feed him his breakfast, that he was not the same as he was the night before. She stated that they do not have a regular nurse on the floor; it is either agency or staff from a sister facility. She stated the nurse's name may have been Staff L, LPN. She stated when she left the other residents' room the EMS was coming out of Resident #8's room doing CPR. She stated that it took about 10 minutes or so. The ADON came out of the room with the EMS. She stated that she did not know if he was a full code or Do Not Resuscitate (DNR). She stated that normally they call a Code Blue. She stated that the aides do what they are told to do: do the report, get the code cart, etc. She stated that they had only practiced a Code Blue once in the [AGE] years that she has been there. She stated that they had never reviewed what to do during a Code. She stated that she had written her statement regarding the incident today, [DATE]. During an interview on [DATE] at 5:13 p.m. Staff J, RN, ADON stated that she came into the facility that morning (,[DATE]) because she had gotten a call that they needed help with the medical records (admissions), putting them together. They needed to check that all the orders were in the computer. She stated that she got the call around 7:30 a.m. and came in around 9 a.m. Staff J stated that she asked Staff D, CNA if there was anyone, she needed to look at first. She stated that Staff D, CNA said Resident #8. They went to look at Resident #8. He had ancillary breathing; his oxygen saturation was in the low 70's. She stated she did not remember his pulse, but his blood pressure was ,[DATE]. She stated she told Staff D, CNA and maybe the nurse that they needed to call 911. She stated that she does not remember if the nurse (Staff L, LPN) was in the room or not. She stated that she ran to the nursing station to call 911. She stated that Staff D, CNA was in the room when she left. She used the phone at the nurses' station. She stated that the resident was on the 400 hall, about way down. She called 911. She stated that it was a blur. Staff J, RN, ADON stated that there was a nurse behind her in the room off the nursing station and she asked her to get the face sheet and orders for EMS. She stated that EMS got there really quickly, like within 4 or 5 minutes and they were there. She stated that she opened the door and walked EMS down the hall to the room. When asked, she stated that Staff D, CNA had been called out of the room, there was a resident yelling for help. Staff J, RN, ADON stated that Staff L, LPN was in the room during the time the vital signs were done and then she went out. Staff J, RN, ADON, stated, I don't know why. She went to her med cart. Staff J stated that Staff L was not in the room during the call to EMS. Staff J, RN, ADON stated she was going to give EMS report and looked down at Resident #8 and he was not breathing. She stated, My mouth dropped open. She stated that she was not sure when he

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F 0684 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) stopped breathing. EMS started CPR. EMS had him on the stretcher and out of the facility within one minute. Staff J stated that at some point we were doing vitals and she was talking to the nurse, Staff L. She stated that Staff L had checked his code status and knew he was a Full Code. She stated she knew he was a Full Code when she called EMS. She stated that his chart was together but not together; it was organized; the orders and the PASRR were there. When asked why a nurse or somebody was not with Resident #8, due to him being in respiratory distress, she stated that Staff K, LPN was in the nursing station and another nurse was in the back room of the nursing station; Staff L, LPN knew he was in respiratory distress and had been there earlier during the time the vital signs had been taken; and another agency nurse was down the hall. Staff J, RN, ADON stated, No, there was no one in the room when she and the EMS went into the room. Staff J, RN, ADON stated, You would have expected Staff L, LPN, that was in charge of him would have stayed with him, but she didn't. She stated, Neither the CNA nor the nurse was in the room with him, I was shocked. She stated that Code Blue was not called. She stated that they only have a Code Blue, we do not have anything other than Code Blue and it is only called if a resident was found unresponsive. She stated that she did ask Staff L, LPN about why she was not in the room. Staff J stated, I was mortified. My mouth dropped open when I realized he was not breathing. I cried after EMS left. She stated that she would assume as a nurse she would have stayed there with him. She stated that she was not aware Code Blue was needed until she went back into the room with the EMS. She stated that Code Blue drills had not been done in the 4 months she has been there. She stated that she did not know if or when the staff had been educated on Code Blue. She stated that Staff L, called the physician and family. She stated she does not know what Staff L, told the family except to make them aware the resident was going to the hospital. During an interview on [DATE] at 4:20 p.m. Staff K, LPN stated that she normally worked the ,[DATE] shift but on ,[DATE], she worked the ,[DATE] shift. She stated that Resident #8 came in at about 8 p.m., she thought. The agency staff that had worked the ,[DATE] shift had not put in the admission. Staff K, LPN had done her walking rounds after midnight and Resident #8 was awake and mouth breathing, his respirations were also elevated. She did not know if he was supposed to have oxygen or not, but he did not have any on. His oxygen saturation was 78%. She initiated oxygen. He did not have a chart and she could not find his paperwork. After locating the paperwork, she found no order for breathing treatments. He had [MEDICAL CONDITION], elevated [MEDICATION NAME] levels and a GI bleed. She stated she remembers his vital signs were low and his oxygen saturation had improved with the oxygen. She called his physician (Dr. N) and he returned the call in about ,[DATE] minutes. He gave the orders to increase the oxygen to ,[DATE] liters per minute and give [MEDICATION NAME] every 4 hours as needed. After the increase in oxygen and [MEDICATION NAME], his oxygen saturation increased to 90%. She stated that the resident stated he felt better. Throughout the night, he was sleeping with his head of the bed elevated, his breathing had slowed down, and his oxygen saturation had stayed stable. She stated she should have documented more regarding his vital signs, etc. in the chart, but she didn't. She stated that he was stable. She gave him the first [MEDICATION NAME] at 1:30 a.m. and another one at 5:00 a.m. He was stable, his vital signs had come up, but his blood pressure was still low, maybe ,[DATE]. She stated that her and the ,[DATE] nurse, Staff L, LPN, did walking rounds together. The resident was awake when they went in his room, He had a cup of thickened water in his left hand. She stated that she helped him put it back on the table, because he was shaky. She stated that she told the nurse, Staff L, to watch him because of his oxygen saturation. She told the nurse the physician was aware. She stated that she was sitting at the nursing station doing her charting, including her medication administration into the MAR indicated [REDACTED]. She was sitting there with Staff O, LPN, another nurse that worked the ,[DATE] shift with her. She stated that she and Staff O notified the ADON that the ,[DATE] shift nurses had not completed the admissions. The ADON decided to come in. She stated that the ADON spoke with her and Staff O regarding the lack of admission documentation input into the computer. She stated that parts of the admissions were incomplete, there were errors, etc. The ADON walked down the hall and asked Staff D, CNA who she should go see first of the new admissions. The ADON came back to the nursing station and stated, how is he on oxygen and his O2 is so low. She stated that she told the ADON that he had been stable and was verbalizing earlier. The ADON called 911. She did not call a Code Blue. The ADON was on the phone explaining about the resident. She stated that she saw the EMS come in within a couple of minutes. The ADON had hung up the phone with EMS, but she was still standing at the nursing station when EMS came in. She stated that she did not know if the ADON had asked any nurse to stay with Resident #8. She stated that the ADON did not ask either her or Staff O to go stay with him. The EMS initiated CPR on the resident. She stated that she would expect to see a nurse with the resident or someone in there with him. She stated that the ADON did not ask her the code status of the resident. She stated that she put the paper chart together and does not know if the ADON had it with her or not. She stated that it took her at least 10 minutes to put the paper chart together, thank goodness we did not have to look for his code status before the chart was put together. She stated she was asked to write a statement today, [DATE], regarding the incident. She stated that she asked Staff D, CNA later about the resident and Staff D had stated that she had to help him eat, which would have been between 7:30 and 8:00 a.m. Staff K, LPN stated that she documented his vital signs on a piece of paper but did not document them in the medical record, I should have. She stated that they had not had a Code Blue Drill in a while. They normally have elopement drills, not Code Blue drills. She stated, They have a lot of agency staff. We don't have enough facility staff. The agency staff does the minimum, pass the pills. During an interview on [DATE] at 2:46 p.m. Staff L, LPN stated that the incident was on ,[DATE], Saturday a.m. She stated that she normally works for a sister facility, but they asked her to help out at this facility. She got report from Staff K, LPN that had worked nights (,[DATE]). She stated that they made walking rounds. Resident #8 was in room [ROOM NUMBER] or 407. Staff K, LPN had told her that he had come in on the ,[DATE] shift. Staff L stated that somebody had said he could not keep his oxygen level up and that they had put oxygen on him. He was stable and had a little bit of [MEDICAL CONDITION]. She stated that she pulled the sheet back and looked at his feet. They walked out and went to another resident's room. She stated that she needed to start medication administration and had been in his room between 7:30 and 7:45 a.m. She was at the nursing station and the ADON came up on her left side, discussing problems. The aide (Staff D, CNA) came up and let her know he had eaten better last night than this morning. Staff D said he was not eating this morning. They (her, the ADON and the CNA) went to the room and his breathing was labored. Staff J, ADON left the room, stating we are going to send him out, and went to the nursing station to call 911. When she left the room, Staff D, CNA was still in the room. She stated that she was unable to find the name of the family on the computer, it was not there. Staff L stated she had to go to the hard chart to find the wife's phone number. She told the wife they were sending him out because he was having respiratory issues. She stated that she was in the room in the back of the nursing station and Staff J, ADON was in the U-shaped nursing station. She stated by the time she found the wife's number and talked to her; the EMS was coming in the door. She stated that Staff J, ADON was standing down the hall, outside the resident's door, flagging the EMS down. She stated that she walked from the nursing station down the hall behind the EMS to his room. She stated that she knew he was a full code, because it was documented in the computer, she noticed it when she was looking for the wife's phone number. Staff J, ADON and the EMS went into the resident's room first. Staff J, ADON was at the door of the resident's room when EMS came down the hall and she, Staff L, followed the EMS down the hall. She stated that she could see Staff J, ADON telling the EMS something, but she could not hear or understand it. She stated that EMS initiated the CPR. They hooked him up to the compression machine. She stated that she went back to finishing the SBAR / Change in Condition form. The EMS took him out on a stretcher doing CPR. She stated that her and the ,[DATE] nurse (Staff K) did walking rounds. She stated that he was fine then. Staff D, CNA and Staff J, ADON and herself were in Resident #8's room. His oxygen was on. The ADON left the room and the aide was still in the room. She stated that she left the room to call the wife, because the number was not in the computer. The ADON was in the hallway, when she looked down the hall from the nursing station after she had called the wife. A Code Blue was not called. She stated that she wrote a note and gave her statement over the phone to the Staff H, RN, RM. She does not remember anyone else at the nursing station. She stated it all occurred within 1 to 1 hours after they had made rounds and first saw him. An interview occurred on [DATE] at 10:15 a.m. with the Nursing Home Administrator (NHA), Staff H, RN RM, and Staff A, RN supervisor regarding Resident #8. The NHA stated she was made aware of the accusation of lack of care, made aware by an employee from the Regional VP of Central Florida and Regional Clinical Director of Clinical Services on ,[DATE]/ 20. They were at the facility and spoke with the NHA. The NHA stated that they met and made a decision this met the requirement for reporting because of the allegation of neglect. They contacted the Department of Family and Services and did an Immediate for AHCA. There was no perpetrator and an investigation were initiated. The investigation was still ongoing at this point. They stated that they had not completed their investigation. Staff H, RN, RM stated that she did a chart review as well as a lab and diagnostic review. She performed a timeline. She had reviewed his chest x-rays and was reviewing the nursing documentation and performing interviews. She had interviewed and or received statements from staff members. She began reading off the written statements

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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 -** Actual harm **Residents Affected -** Few	(continued... from page 3) that had been turned in. She interviewed Staff L, LPN over the phone. Staff P, CNA was who was on duty through the night on the ,[DATE] shift. Her statement showed she was assigned to the resident and provided care and needs frequently through the night. She stated she was aware of his shortness of breath and saw he had a pulse oximeter on his finger that was reading ,[DATE]%. She stated she was in his room every hour or so. At 5 a.m. he was comfortable and resting. Staff L, LPN had the resident on the ,[DATE] shift, when he was transferred to the hospital. Her statement showed that basically he was fine. Sometime shortly after breakfast he became short of breath according to the CNA. The CNA made her aware at approximately 9 a.m. that this morning (,[DATE]) he needed more help eating than he needed last night. That was all that was said in her statement. Staff D, CNA took care of him on the ,[DATE] shift and the ,[DATE] shift. She stated that he could eat the night before but needed some assistance for breakfast, that he did not need prior. He had a change in his consumption of food. Staff H, RN, RM stated that it was a 6-page statement and she was telling the surveyor the highlights. He was admitted around 5:30 p.m. His vital signs were normal at that time. She went to get him a supper tray, and he was able to feed himself. He was able to answer questions. He was not coughing, and his color was good, he was not having trouble breathing. When he was brought in, the transport company was concerned that his oxygen saturation kept dropping on the way to the facility. She stated that her last time seeing him was around 10 p.m. on ,[DATE] when she did her last rounds to make sure everyone was clean and dry. She asked him if he needed anything and he said no he was fine. The transport company had made a comment they to put him on oxygen to keep his oxygen sats up. On the ,[DATE] shift, the nurse had to call to get an order for [REDACTED]. His appetite was poor, he only ate 25 % and his color was pale. At around 9:30 a.m. the ADON came in the facility and asked her which resident needed to be seen first. She directed her to Resident #8. The ADON and Staff D, CNA went to get him ready to go to the hospital. She stated that she stayed with him. The EMS was there and he was on the stretcher and they were doing CPR. The ADON's statement showed she came to the facility around 9 am. to work on admissions. She did ask Staff D, CNA which resident to look at first. She checked on Resident #8. She stated that he was lethargic and had difficulty breathing. She took his vitals and called 911. She stated that she stayed on the phone until EMS arrived. She stated that EMS left with the resident doing CPR. Staff K, LPN was the night nurse and mentions in her report as the ,[DATE] nurse. On first assessment he was awake and alert, and verbalizing. But describes him of showing mouth breathing and use of accessory muscles. She wrote she checked his oxygen saturation on room air and he was at 78%. She started him on oxygen and instructed on purse lip breathing. He was alert and able to follow commands. His oxygen saturation was up to 85%. She called his physician and received new orders to increase the oxygen to ,[DATE] liters per minute and give [MEDICATION NAME] now and every 4 hours. She explained to the resident his oxygen saturation was at ,[DATE]% after the treatment. He stated he felt a bit better. His breathing was better. She stated that she checked on him every 30 minutes. He maintained his oxygen saturation at 90 % on 3 liters of oxygen. She stated that the aide did not report anything throughout the night. She had to wake him for another breathing treatment which he accepted. After the treatment he fell back to sleep. He maintained a oxygen saturation of 90%. She stated she did walking rounds with the ,[DATE] nurse (Staff L, LPN). She gave report. Both nurses went into the resident's room, he was holding a cup of thickened water, she stated that she helped him put it back on his bedside table. She told the nurse (Staff L, LPN) to closely monitor him. Staff H, RN, RM stated that she had spoken with Staff K, LPN, Staff D, CNA and Staff P, CNA, and Staff L, LPN over the phone. She stated that she spoke with J, RN, ADON in person. She had spoken directly with them as well as received their written statements. During an interview on [DATE] at 4:55 p.m. Physician Q stated that he did not see Resident #8, he never met him. He stated the nurses may have called him for orders for oxygen, but he never saw him. He stated that sometimes the facility was late in calling him about a new admission. He stated that sometimes the facility was late about performing labs, following orders and starting IV's. He stated that it was off and on. He stated that they were not consistent about calling him with labs and issues. They use a lot of agency staff and they are not familiar with the procedures of the facility. He stated that he has not complained to the administration about the care but has talked to the supervisor on the floor about issues. Record review of the facility's policy, Notification of Chang in Condition, revised [DATE] revealed the Center to promptly notify the Patient / Resident, the attending physician, and the Resident Representative when there is a change in the status or condition. The nurse to notify the attending physician and Resident Representative when there is a (n): significant change in the patient / resident's physical, mental, or psychosocial status; need to alter treatment significantly; new treatment; a transfer or discharge of the Patient / Resident from the Center. IN the event of an emergency situation, 911 to be called and the attending physician and the Resident Representative to be notified as soon as possible. The nurse to complete an evaluation of the Patient / Resident. Document evaluation in the medical record. If there is a Registered Nurse available, the Registered Nurse will perform an evaluation of the resident and document results of evaluation in the medical record. LPN will notify the Registered Nurse on shift with a suspected change in condition of a resident observed by that LPN, to complete an assessment. The nurse will contact the physician. Notify the resident and the resident representative of the change in condition. Document notification in the medical record. Document resident change in condition on 24-hour report. Complete SBAR as indicated. Record review of the facility's policy, Daily Skilled Nursing Progress Note, revised on [DATE] showed residents receiving skilled care have progress documented daily in the medical record by the nurse. Use the Daily Skilled Nurse's Note to document resident's progress daily. Document abnormal findings in a narrative note on the form. Also document in a narrative note the indications for continued skilled care using the Skilled Documentation Reference Guidelines. Record review of the facility's policy, Admissions Assessment, revised on [DATE] shoed at the time of admission or readmission, the Nurse shall initiate the Data Collection Form. Pertinent Information shall be collected by physical review, interview with resident and family and review of the resident's available medical records. The Data Collection Form will be completed within 24 hours. Initiate care plan.
F 0694 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide for the safe, appropriate administration of IV fluids for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility did not administer [MEDICATION NAME] fluids in a timely manner to prevent harm for 1 (Resident # 7) of 3 residents sampled for intravenous (IV) fluid administration. The facility delayed ordered IV therapy to a resident who was at risk for dehydration related to [MEDICAL CONDITION], adult failure to thrive, severe protein-calorie malnutrition, dementia, and hypertension. The facility failed to transcribe physician's orders [REDACTED].#7. Findings included: A review of Resident #7's medical record revealed that Resident #7 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of Resident #7's care plan revealed that Resident #7 was at risk for imbalanced nutrition related to cognitive loss, adult failure to thrive, advanced age, dementia, hypertension, history of severe protein-calorie malnutrition, and significant weight loss. Interventions included administer medications as ordered and obtain and monitor lab/diagnostic work as ordered and to report results to MD and follow up as indicated. A review of Resident #7's physician's orders [REDACTED]. The ordered laboratory testing included Complete Blood Count (CBC), Comprehensive Metabolic Panel (CMP), Urinalysis (UA), Culture and Sensitivity (C&S), and ammonia level. A review of Resident #7's Progress Notes revealed an Electronic Medical Record (eMAR) Shift Level Administration Note, dated on 10/09/20 at 06:18 AM, which stated that lab work was completed for CBC and CMP as well as collection for the UA and C&S testing. Resident #7's Progress Notes also revealed a Physician's Progress Note, dated on 10/09/2020 at 02:21 PM, completed by the facility's Medical Director. The Physician's Progress Note revealed that the Medical Director was alerted by nursing staff that Resident #7 had a poor appetite and increased weakness and lethargy. Blood work was obtained on 10/09/2020 and was reviewed by the Medical Director. The assessment documented in the Physician's Progress Note revealed that Resident #7 was experiencing increased confusion as indicated by a +++ in the note as well as generalized weakness. The Physician's Progress Note documented, under the section titled Impression, [MEDICAL CONDITION], dehydration, failure to thrive, and anorexia. The Physician's Progress Note documented, under the section titled Plan, 1/2 Normal Saline (NS) at 125 Cubic Centimeters (CC) an hour for 1 liter via IV, then 1/2 NS at 75 cc an hour for 48 hours total, recheck Basic Metabolic Panel (BMP) on 10/10/2020, order faxed to North and South side. A review of Resident #7's Telephone Orders revealed an undated order for 1/2 NS at 125 cc an hour for 1 liter, then 1/2 NS at 75 cc an hour for 48 hours, recheck BMP in AM. The Telephone Order was signed by a physician on 10/11/2020. A review of Resident #7's laboratory testing results, dated on 10/09/10, revealed an increased sodium level of 157 milliequivalents per liter (mEq/L). The laboratory testing results also revealed a hand written note at the bottom stating that the results were faxed to the Medical Director on 10/09/2020 at 01:45 PM. A second copy of the same laboratory testing results revealed that the laboratory results were reviewed by the Medical Director on 10/09/2020 with hand written orders at the bottom for 1/2 NS at 125 cc an hour for 1 liter IV, then 1/2 NS at 75 cc an hour for 48 hours, recheck BMP on 10/10/2020. A review of Resident #7's Progress Notes revealed a Nursing Progress Note, dated 10/11/2020 at 01:15 PM, documented by Staff R, Registered Nurse (RN). The note revealed that the Medical

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	106002	A. BUILDING _____ B. WING _____	10/18/2020

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F 0694 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 4) Director was in the facility and an order was received for 1/2 NS at 125 cc an hour for 1 liter IV, then 1/2 NS at 75 cc an hour for 48 hours, recheck BMP in the AM for dehydration. A Nursing Progress Note, dated 10/11/2020 at 03:11 PM revealed that Staff R, RN placed a 22 gauge IV to Resident #7's right forearm and that Resident #7 pulled out the IV line. A Progress Note, dated on 10/11/2020 at 04:40 PM revealed that Staff S, Licensed Practical Nurse (LPN) attempted two more times to access Resident #7's vein for IV placement but was not successful. The note also revealed that the Medical Director was notified following the procedure and a new order was given to send Resident #7 to the hospital due to dehydration. An interview was conducted on 10/17/20 at 12:21 PM with Staff J, Assistant Director of Nursing (ADON). The ADON stated that the labs are put into the computer by the 11 PM - 7 AM shift. The 11 PM - 7 AM staff put in the order for the lab work, put in a requisition, and put that in the lab book. The Staff J, ADON then prints the labs that are supposed to be done and gives a copy to the floor nurse. The floor nurse was to check on the labs during their shift. The lab faxes the results to the facility and if lab results don't come, then the floor nurse was to follow up. Lab work could also be obtained from the lab's website. Lab work typically gets reviewed during morning meetings Monday through Friday. Staff J, ADON stated that Staff A, RN Unit Manager had been assigned to follow up on lab work and that it was not always completed. An interview was conducted on 10/18/2020 at 02:37 PM with Staff M, LPN. Staff M, LPN stated that she was informed that Resident #7 was refusing to eat and drink for a day or two and she contacted the Medical Director. The Medical Director ordered some blood work as well as a UA C&S. The lab work came back on 10/09/2020 around 01:30 or 02:00 PM. Staff M, LPN stated that she did not receive a response by the end of her shift at 3 PM. Staff M, LPN stated that if an order for [REDACTED]. A review of the facility's EDK kit contents list revealed that 1/2 NS was available in IV Kit A for administration. A follow up interview was conducted on 10/18/2020 at 06:26 PM with Staff J, ADON. Staff J, ADON stated that staff did not report to her that Resident #7 was not eating or drinking and that she was not aware of of the IV therapy being delayed. IV therapy should not have been delayed and that nursing staff should have documented the Medical Director's response to the lab work that was done. Staff J, ADON stated that the facility did not have a Unit Manager for that side of the building or a weekend supervisor, which may have caused some of the lab work to not be followed up on. An interview was conducted on 10/20/2020 at 04:55 PM with Staff Q, Physician. Staff Q, Physician stated that sometimes the facility was late about performing labs, following orders, and starting IV's and that staff was not consistent about calling him with lab results or issues that came up. Staff Q, Physician stated that the facility used a lot of agency staff and that they were not familiar with the procedures that the facility used and that he had discussed the issues with supervisors at the facility. An interview was conducted on 10/23/2020 at 08:07 AM with Staff R, RN. Staff R, RN stated that she was informed on 10/11/2020 by another nurse that Resident #7 was not eating or drinking well and that the Medical Director was aware. The Medical Director gave her an order to start an IV that day and she was able to place the IV site but Resident #7 pulled it out and the Medical Director was notified. Staff S, LPN also attempted to start the IV but was unsuccessful. The Medical Director then gave an order to send Resident #7 to the hospital. Staff R, RN stated that the 1/2 NS was available in the EDK and that she had it ready to administer but she could not. A telephone interview was attempted with the facility's Medical Director on 10/20/2020 at 03:25 PM and 10/23/20 at 08:37 AM. A message was left with the Medical Director's Medical Assistant on both occasions, but a telephone call was not returned.
F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide sufficient staffing to meet the needs of the residents to ensure resident safety, and maintain the highest practicable physical, mental and psychosocial well-being of each resident. Findings included: On 10/16/20 at 7:45 p.m., an initial tour of the 200, the 300, the 400 and the 500 halls was conducted. The residents were observed to be mainly in bed. The corridors were observed to be free from clutter. Behind the nursing station in the nursing room were three nurses chatting and a fourth nurse sitting at the nursing station with a mask in place but lacked eye protection. The staffing board showed for these floors showed there were 5 aides assigned to these 4 floors. Staff A, Registered Nurse (RN), Supervisor was only able to locate one aide on the halls and she was in the shower room with a resident. The other 4 were on their 30-minute break. While the surveyors were in the parking lot of the facility at approximately 7:35 p.m. we observed 2 staff members getting into a car. While we were entering the building a third staff member was exiting the facility. Per Staff A, RN supervisor, Staff B, Certified Nursing Assistant (CNA) was working the 200 hall, but she was on break. The supervisor thought that she was in the break room, but on inspection she was not in the break room. The supervisor stated that Staff B, CNA did not tell anyone she was leaving the facility. She was one of the employees observed leaving in the car. She returned to the facility at approximately 8:10 p.m. Staff C, CNA left on break at approximately the same time as the other three and returned to the facility at 8:12 p.m. Staff D, CNA also was gone on break and she returned at approximately 8:10 p.m. with Staff B. Staff E, CNA was also unable to be located, the floor nurse stated that she was not aware that she had left for a break. Staff F, CNA which worked on the other side of the building was the staff member exiting the building when the surveyors were entering at approximately 7:40 p.m. The nurse on that side of the building stated the aide had left without telling her she was leaving. On interview Staff A RN, supervisor stated that the aides were supposed to let the nurses know when they go on break. They are also supposed to alternate and cover for each other. She stated that 4 of the 5 aides went on break at the same time. There was one aide left on the floor and she was showering a resident. Staff A, stated, all the nurses were here. Staff A, RN supervisor was observed telling the aides that they had just had the conversation about this (leaving on break at the same time and informing the nurse of your where abouts). During an interview on 10/16/20 at 8:10 p.m. Staff D, CNA stated that she had been working here for [AGE] years. She stated that some days it is terrible. She stated that the aides do not always check on their residents. She stated that staffing meets the guidelines of 1 to 20, but not how much time it takes to care for the residents. When asked about abuse training, she stated that she would tell the hall nurse, but she does not always know the nurses anymore, because we have a lot of agency staff. During interview on 10/16/20 at 11:44 p.m. Staff G, CNA stated that staffing was pretty good, especially now that they are using agency. An interview on 10/18/20 at 10:15 a.m. with the Nursing Home Administrator (NHA) and Staff H, RN, Risk Manager (RM) and Staff A, RN supervisor occurred. The NHA stated that they had identified that they were meeting the ratio requirement. They added an additional agency staff member to provide additional staffing. They know they have a couple of agency staff on the day shift and more on the evening and night shift. She stated that they identified in the last week that on the 11-7 shift that they had a night shift that had been staffed by all agency staff members at the same time. She stated that their night shift staff had all resigned due to retirement and they had not been replaced yet. Two members resigned just last week, and one was in late September and one the first of October. The NHA stated that it was concerning having all agency and no full-time employees at night. When asked how they were ensuring the residents were being cared for with so many agency staff members, Staff A, RN supervisor stated that they review the new admissions, 24-hour report, order listing report, and dashboard for any alerts which give a clinical synopsis in morning meeting. When asked, she stated yes, they only meet Monday through Friday. She stated that Staff J, Assistant Director of Nursing (ADON) monitors the facility on the weekends from her home computer. Staff A stated that they did not have a weekend supervisor at this time. Staff A, RN, stated, they were having a rough time, right at this time. The NHA stated that they had a new Unit Manager starting on October 26 and was going to be the weekend supervisor working Thursday through Monday. During an interview on 10/20/20 at 4:55 p.m. Physician Q stated that sometimes the facility was late in calling him about a new admission. He stated that sometimes the facility was late about performing labs, following orders and starting IV's. He stated that it was off and on. He stated that they were not consistent about calling him with labs and issues. They use a lot of agency staff and they are not familiar with the procedures of the facility. He stated that he has not complained to the administration about the care but has talked to the supervisor on the floor about issues. #2 An interview was conducted on 10/16/2020 at 08:08 PM with Staff F, Certified Nurse's Aide (CNA). Staff F, CNA stated that 5 CNA's were assigned to the 500, 700, and 800 side of the building during the 3 PM to 11 PM shift that evening. Staff F, CNA was able to identify 1 of the 4 other CNA's on the floor during the interview and stated that 3 of the CNA's were on break, leaving 2 CNA's on that side of the building. Staff F, CNA stated that the facility did not use a schedule for breaks and that staff was not assigned to a specific break time. Staff was not required to sign out for their breaks, but

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F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 5) they should let the other CNA's know when they are leaving for their break. Staff F, CNA was not able to state when the remaining CNA's would return from their breaks.
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility did not provide pharmaceutical services to meet the needs of 1 (Resident #6) of 3 residents sampled for antibiotic therapy. Findings included: A review of Resident #6's medical record revealed that Resident #6 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of Resident #6's care plan revealed that Resident #6 had episodes of bladder incontinence, with interventions to monitor/document for signs and symptoms of UTI. A review of Resident #6's physician's orders [REDACTED]. Resident #6's physician's orders [REDACTED]. A review of Resident #6's laboratory testing results, dated 10/04/2020, revealed abnormal results and presence of Providencia Stuartii organism in Resident #6's urine culture. A hand written note on the bottom of Resident #6's laboratory testing results revealed an order for [REDACTED]. A review of Resident #6's Progress Notes revealed a Physician's Progress Note, dated 10/01/2020 at 08:52 PM, completed by the facility's Medical Director. The Physician's Progress Note revealed that the Medical Director was alerted that Resident #6 complained of having cloudy and malodorous urine. The assessment documented in the Physician's Progress Note revealed that Resident #6 was experiencing burning or pain with urination. The section of the Physician's Progress Note titled Plan revealed that a review of Resident #6's UA and C&S would be conducted. A Physician's Progress Note, dated 10/04/2020 at 11:28 PM was completed by the facility's Medical Director. The Physician's Progress Note revealed that Resident #6's urine culture contained presence of Providencia Stuartii organism. The section of the Physician's Progress Noted titled Plan revealed an order for [REDACTED]. The ADON stated that the labs are put into the computer by the 11 PM - 7 AM shift. The 11 PM - 7 AM staff put in the order for the lab work, put in a requisition, and put that in the lab book. The Staff J, ADON then prints the labs that are supposed to be done and gives a copy to the floor nurse. The floor nurse was to check on the labs during their shift. The lab faxes the results to the facility and if lab results don't come, then the floor nurse was to follow up. Lab work could also be obtained from the lab's website. Lab work typically gets reviewed during morning meetings Monday through Friday. Staff J, ADON stated that Staff A, RN Unit Manager had been assigned to follow up on lab work and that it was not always completed. An interview was conducted on 10/18/2020 at 06:01 PM with Staff K, Licensed Practical Nurse (LPN). Staff K, LPN stated that Resident #6 had asked her about her antibiotic on 10/06/2020 and stated that she thought that she was being started on an antibiotic but was not given the antibiotic yet. Staff K, LPN checked Resident #6's Medication Administration Record [REDACTED]. Staff L, LPN looked further into Resident #6's chart and discovered that the Medical Director had written a Progress Note indicating the start of the antibiotic on 10/04/2020. Staff K, LPN stated that she did not see any recent lab work in Resident #6's chart at that time. Staff L, LPN stated that she pulled the [MEDICATION NAME] 1 gram IM from the Emergency Drug Kit (EDK) and administered the first dose as ordered on [DATE]. An interview was conducted on 10/18/2020 at 06:15 PM with Staff A, RN Unit Manager. Staff A, RN Unit Manager stated that Resident #6's lab results were brought to the attention of the Medical Director on 10/06/2020 and that the Medical Director told her that she already gave orders to start antibiotic therapy. Staff A, RN Unit Manager stated that perhaps the nurse working that night did not follow up with the order and that the normal process would be to obtain the first dose of the medication from the EDK and start it when the ordered was received. An interview was conducted on 10/20/2020 at 03:45 PM with the facility's Consultant Pharmacist. The Consultant Pharmacist stated that upon receiving an order for [REDACTED]. The Consultant Pharmacist verified that [MEDICATION NAME] 1 gram IM would be available in the facility's EDK and that the medication should have been started upon receiving the order. An interview was conducted on 10/20/2020 at 04:55 PM with Staff Q, Physician. Staff Q, Physician stated that sometimes the facility was late about performing labs, following orders, and starting IV's and that staff was not consistent about calling him with lab results or issues that came up. Staff Q, Physician stated that the facility used a lot of agency staff and that they were not familiar with the procedures that the facility used and that he had discussed the issues with supervisors at the facility. A telephone interview was attempted with the facility's Medical Director on 10/20/2020 at 03:25 PM and 10/23/20 at 08:37 AM. A message was left with the Medical Director's Medical Assistant on both occasions, but a telephone call was not returned.
F 0886 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to follow the Centers for Medicare and Medicaid Services related to testing of all staff including individuals providing services under arrangement and obtaining documentation the required testing was completed during the timeframe that corresponds to the facility's testing frequency. The facility also failed to ensure a staff member that tested positive for COVID-19 was not allowed to work for at least 10 days after the date of their first positive diagnostic test. Findings included: 1. An interview on 10/18/20 at 10:15 a.m. with the Nursing Home Administrator (NHA) and Staff H, RN, Risk Manager (RM) and Staff A, RN supervisor occurred. When asked how they ensure COIVD-19 testing for agency and vendor / ancillary providers? The NHA stated that the agency staff was tested , and the staffing coordinator managed it through the agency portal and or test results. The NHA stated that they test the agency staff at the facility, because they have adequate testing supplies. The staffing coordinator staffs based on the test results. She stated that they have a staffing meeting daily and they review the testing results of the staff. When asked how they ensure the vendors and ancillary providers have been tested according to the requirements like labs, radiology and Hospice. The NHA stated that they were not required to ensure Hospice staff had been tested . The Hospice nurses were only visiting for a change in condition and only making weekly visits. She stated that the Hospice aides were not coming in at this time. They only have 11 residents receiving Hospice services at this time. She stated that they were contractors and should be using the Health Care Practitioner questionnaire. She stated that the vendors like the lab and radiology fill out the questionnaire stating that they had been tested and add a date. The NHA stated that no one was actually looking at the test results to verify they had a negative test and the date was within the time frame. She stated that the Practitioners, yes, provided their test results. When asked who visited to insert IVs if the staff was not able, she stated the pharmacy. She stated again, they do not look at the pharmacy staff's test either to verify the test results, they just get a date on the screening tool. She stated the podiatrist came in last week for the first time since the pandemic and she did not look at his test personally either. When informed the definition of the Healthcare Personnel (HCP) by CDC included but are not limited to Emergency medical service personnel, nurses, nursing assistants, physicians, technicians, therapists, phlebotomists, pharmacists, students, students and trainees, contractual staff not employed by the healthcare facility and persons not directly involved in patient care, but who could be exposed such as clerical, dietary, environmental services, laundry, security and engineering and facilities management, administrative, billing and volunteer personnel. The NHA had no further comment. Record review of the Centers for Medicare and Medicaid Services QS)-20-38-NH dated August 26, 2020 showed the LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility. The Facility Staff includes employees, consultants, contractors, volunteers, and caregivers who provide care and services to residents on behalf of the facility. We know the facility may have a provision under its arrangement with a vendor or volunteer that requires them to be tested from another source. However, the facility is still required to obtain documentation that the required testing was completed during the timeframe that corresponds to the facility's testing frequency, as described in Table 2. 2. During an interview on 10/16/20 at 8:10 p.m. Staff I, Licensed Practical Nurse (LPN) stated that they were tested weekly for COVID-19 at this time. She stated it used to be every other week but now it is weekly. She stated that she tested positive in August and was off for 10 days. She stated that she did not have any symptoms. She stated that she tested positive on August 8, she thought. She was off the day she tested positive and the supervisor called her to tell her. She was scheduled to work the next day, so she was taken off the schedule. The facility kept up with her. Review of the Employee Line listing showed Staff I, Licensed Practical Nurse (LPN) was tested on [DATE] and received positive results on 08/13/20. It was documented that she was eligible to return to work on 08/22/20 (10 days after test date). On review of Staff I, LPN's time sheet, it showed she returned to work on 08/21/20. During interview on 10/18/20 at 3:18 p.m. the Nursing Home Administrator (NHA) stated that she should not have come back to work until 08/22/20, not 08/21/20. She came back prior to her 10-days. Record review of the Centers for Disease Control and Prevention, Criteria for Return to Work for

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WEDGEWOOD HEALTHCARE CENTER	**1010 CARPENTERS WAY LAKELAND, FL 33809**

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 0886 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 6) Healthcare Personnel with [DIAGNOSES REDACTED]-COV-2 Infection (Interim Guidance) Return to Work Criteria, updated August 10, 2020 showed HCP who are not severely immunocompromised and were asymptomatic throughout their infection may return to work when at least 10 days have passed since the date of their first positive [MEDICAL CONDITION] diagnostic test. Review of the facility's policy, COVID-19 Pandemic Plan, revised on 10/14/20 showed under EMPLOYMENT HEALTH practices are in place that addresses the needs of symptomatic staff and facility staffing needs, including: determining when staff may return to work after having COVID-19 according to CDC guidelines and in coordination with local and /or state health department (Refer to the Guidance for Care Givers with Potential Exposure to a Patient under Suspicion of COVID-19 or tested Positive for COVID-19).