STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105153	A. BUILDING _____ B. WING _____	**09/03/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PINECREST REHABILITATION CENTER	**13650 NE 3RD COURT NORTH MIAMI, FL 33161**

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 0641 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to accurately document assessments and care provided after an elevated axillary temperature from 101.5 degrees Fahrenheit (F) to 102.9 degrees Fahrenheit for 1 out of 3 residents reviewed (Resident #1) as evidenced by: the lack of follow up assessment documentation in clinical records after an elevated axillary temperature of 101.5 degrees Fahrenheit and failed to accurately documented resident significant change from baseline as evidenced of an elevated temperature (Resident #1); failed to accurately document resident care consistent with the physician orders [REDACTED].#4) reviewed for pressure ulcer as evidenced by the nursing staff signing off for an air mattress that was not in place for Resident #4 as ordered by the physician. The findings included: Review of the facility's policy titled Fever/[MEDICAL CONDITION]- Clinical Protocol undated, documents under Assessment/Evaluation/Recognition A nurse will assess a resident with a suspected infection and will document related findings .the nurse will report findings to the physician .the nurse will discuss with the physician whether a temperature elevation .presence of a fever indicates an infection .relatively sensitive temperature predictors of infection include: an increased temperature of at least 2 degrees Fahrenheit .a single temperature reading above 100 degree Fahrenheit .the nurse will identify, document and report to the physician any evidence of possible infectious complications . documents under Management Nursing staff will collaborate with the physician to distinguish individuals whose condition can be managed in the facility from those requiring hospital transfers .significantly unstable vital signs .may indicate possible need for hospitalization .documents under Monitoring and Follow-up Nursing staff will evaluate the progress of individuals with fever .until the symptoms resolve .the nurses will communicate with the physician by phone about resident status . Review of the facility's policy titled Notification/Change in a Resident's Condition or Status revised on 8/2018, documents our facility shall promptly notify the resident, his or her Attending Physician .of changes in the resident's medical /mental .condition .the nurse will notify the resident's Attending Physician or physician on call when there has been a .significant change in the resident's physical condition .a significant change of condition is a major decline .in the resident's status that will not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions .impacts more than one area of the resident's health status .the nurse will record in the resident's medical record information relative to changes in the residents medical/mental condition status . 1) Review of Resident #1's medical record documented an admission to the facility from an acute care facility on 02/05/20. The medical record documented [DIAGNOSES REDACTED]. Review of Resident #1's Health Status Note dated 02/19/20 17:30 documented resident in bed awake alert .skin warm and dry to touch .congestion noted, breathing treatment administered .oxygen 2 liters via nasal cannula in progress, vital signs: temperatures 101.5 F, pulse 98, respirations 20, blood pressure 104/62, oxygen saturation 96%, safety and comfort maintained, call in reach, we will continue to monitor. Review of Resident #1 Orders-Administration Note dated 02/19/20 timed 17:33 documented Tylenol tablet 325 mg- give 2 tablets by mouth every 4 hours as needed for pain, fever .temperature greater than 101 . Review of Resident #1's Orders-Administration Note dated 02/19/20 timed 19:25 documented Tylenol tablet 325 mg- PRN (as needed) administration was effective . Review of Resident #1's Health Status Note dated 02/19/20 timed 20:50 documented Resident transfer to a local hospital via 911, MD (medical doctor) aware and resident family were here. Review of Resident #1's Health Status Note dated 02/19/20 timed 20:50 documented Resident in bed wake alert instead of going down resident T go from 101.5 to 102.9, and the BP (blood pressure) decrease from 104/62 to 61/48, O2 (oxygen) sat (saturation) 98% with oxygen at 2 liters via NC (nasal cannula), 911 called, awaiting arrival, staff at bedside. Review of Resident #1's Medication Administration Record [REDACTED]. Further review revealed lack of documentation of Resident #1's re-evaluation/follow up of physical status from 17:33 to 20:50. The medical record lacked documentation of the resident temperature reading after administration of Tylenol. Furthermore, the medical record lacked evidence of notification of resident's significant change of a temperature of 101.5 F at 17:33 to the physician. On 09/03/20 at 9:20 AM, Staff A, a Licensed Practical Nurse, stated that the physician would be called if a resident developed any signs of distress, vital signs changes such a temperature, a change of status. Staff A stated that if a resident develops a fever, she would administer Tylenol as per physician orders, apply cold compress, give fluids, recheck the resident's temperature 30 minutes after the Tylenol administration and call the doctor. Staff A added that if new orders are received, she would proceed with the new orders. Staff A stated that she would document the resident's status and interventions on a health status note. On 09/03/20 at 2:26 PM, the Director of Nursing stated that on 02/19/20, Resident #1 had a temperature of 101.5 F, a breathing treatment and 2 Tylenol were given at 17:33 and that the Tylenol's were effective per documentation at 19:25. The Director of Nursing was asked what Tylenol effective meant and in response the Director of Nursing stated that it meant the temperature was decreased. She was asked for the resident's temperature after re-evaluation of the Tylenol administration and she was not able to find documentation related to Tylenol effective documented at 19:25. The Director of Nursing stated that if a resident has a fever and is medicated, the nurses should have rechecked the resident's temperature one hour after been medicated. The Director of Nursing stated that the nurse should have called the physician with Resident #1's temperature of 101.5 F at 17:33. The Director of Nursing confirmed the lack of documentation related to the resident change of condition and care from 17:33 to 20:50 when the resident was transferred out to the hospital. The Director of Nursing was unable to provide any nursing documentation related Resident #1's change of condition notification to the physician on 02/19/20 at 17:33 or before 20:50. During the interview, the Director of Nursing was asked to contact the nurse for Resident #1 on 02/19/20 at 17:33 the Director of Nursing stated that the nurse was not available for an interview. Review of Resident #1's temperature record history documentation revealed: 02/19/20 at 03:04 an axillary temperature of 98.4 F 02/19/20 at 08:22 a tympanic temperature of 96.9 F 02/19/20 at 17:33 an axillary temperature of 101.5 F 02/19/20 at 17:40 an axillary temperature of 101.5 F 02/19/20 at 20:16 an axillary temperature of 102.9 F Further review the resident temperature reading history from 02/08/20 to 02/18/20 documented temperature readings range from 96.8 F (02/10/20) to 98.6 (02/18/20) Fahrenheit degrees. Medical record documented a significant change of the resident's baseline temperature on 02/19/20 at 17:33. Review of the facility's assessment, communication and progress note titled SBAR (Situation, background, assessment, request) for Resident #1 dated 02/19/20 at 20:14 documented blood pressure 61/48; at 20:15 Pulse 112; Respirations 18; at 20:16 temperature 102.9-axilla; new or worsening behavioral symptoms; shortness of breath. The SBAR (B for background) information related to the resident's [MEDICAL CONDITION]/urine compared to baseline was not documented. The resident's medical record documented a physician order [REDACTED]. Review of the facility transfer forms also lacked evidence of the resident's urinary catheter insertion date. Review of Resident #1's physician progress notes [REDACTED].denied any fever .no congestion .awake, alert and oriented to person, place, situation .appears in no distress .assessment- acute respiratory distress, [MEDICAL CONDITION]; plan-transfer to hospital . On 09/03/20 at 3:18 PM, during an interview, the Director of Nursing was asked to contact Resident #1's practitioner/provider. The Director of Nursing attempted to call the practitioner and stated that the Advance Registered Nurse Practitioner (ARNP) was not available. On 09/03/20 at 3:26 PM, a second telephone call was made to the ARNP. The ARNP stated during the

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

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F 0641 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) telephone interview that she vaguely remembered Resident #1. The ARNP explained that she is in the facility at different times of the day and did not recall if she was in the facility on 02/19/20 to evaluate Resident #1. The ARNP was asked if she had any documentation related to a call from the facility's nurse regarding Resident #1's elevated temperature on 02/19/20 as indicated in the facility's documents. The ARNP stated that she does not keep documentation on residents and new orders given to the facility nurses. The ARNP was unable to confirm communication with the facility's nurses on 02/19/20 between the hours of 17:33 to 20:50. 2)Review of Resident #4's medical record revealed an initial admission date of [DATE] and a readmission from an acute care hospital on [DATE]. Clinical [DIAGNOSES REDACTED]. Review of Resident #4's medical records revealed physician orders [REDACTED]. Review of the resident treatment administration record documented air mattress. The treatment administration records indicated where nursing staff signed off for the air mattress from 07/08/20 through 09/03/20. Review of the resident's wound care telemedicine follow up evaluation dated 09/03/20 documented unstageable (due to necrosis) wound of the left heel with 100% necrotic tissue; wound progress-no change; continue with treatment plan. On 09/03/20 at 10:15 AM, observation and interview revealed Resident #4 in bed with blue boots on both feet. Resident #4 and stated that she is been turned from side to side and that her foot dressing was done. Resident # 4 was unable to state if her mattress had been changed within the last two days. On 09/03/20 at 10:20 AM, an interview was conducted with Staff B, a Licensed Practical Nurse. Staff B stated that she did Resident #4's left heel wound care a half an hour ago and added that she was not aware that she needed to wait for the surveyor to observe her wound care. Staff B was asked to show Resident #4's left heel dressing. On 09/03/20 at 10:22 AM, a side by side observation of Resident #4 with Staff B revealed both feet with boots and a dry clean dressing, dated 09/03/20 on the resident's left heel. During the observation, Staff B was asked what kind of mattress Resident #4 had. Staff B stated that Resident #4 had a regular mattress. Staff B was asked if the resident was supposed to be on an air mattress, Staff B stated Yes. Staff B asked how long Resident #4 has been without an air mattress. Staff B was unable to state a timeframe that Resident #4 has been without an air mattress. Staff B was apprised that she (Staff B)signed off that Resident #4 currently had an air mattress in place. Staff B stated that she did not realize that Resident #4 did not have the air mattress in place. On 09/03/20 at 1:38 PM, Staff C, a Certified Nursing Assistant, stated that she did not notice that Resident #4 did not have an air mattress in place during the morning care. On 09/03/20 at 1:40 PM, the Director of Nursing stated that a resident can get an air mattress the same day that it is ordered. The Director of Nursing was apprised that Resident #4 had a physician order [REDACTED]. During the interview the Director of Nursing was asked multiple times to submit the facility policy related to following new physician orders. On 09/03/20 at 2:05 PM, a telephone interview was conducted with the wound care nurse. The Wound Care nurse stated Resident #4 wound is stable and does not need an air mattress. The wound care nurse was apprised that the resident has an order for [REDACTED].
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 observations, interviews and record review, the facility failed to provide care and services in accordance with the professional standards of practice, to meet the resident's physical needs for 2 of 3 residents reviewed (Resident #1 and #4) as evidenced by: the lack of follow up assessment after an elevated axillary temperature of 101.5 degrees Fahrenheit and failed to notify the resident's physician of a significant change in baseline as evidenced of an elevated temperature for Resident #1; 2) failed to implement resident care consistent with the physician's orders [REDACTED].#4) reviewed for pressure ulcer placing the resident at risk for potential worsening of the in-house acquired left heel pressure ulcer and risk of developing a new pressure ulcers as evidenced by the lack of an ordered air mattress for Resident #4. There were 59 residents residing in the facility at the time of this survey. The findings included: Review of the facility's policy titled Fever/[MEDICAL CONDITION]- Clinical Protocol undated, documents under Assessment/Evaluation/Recognition A nurse will assess a resident with a suspected infection and will document related findings .the nurse will report findings to the physician .the nurse will discuss with the physician whether a temperature elevation .presence of a fever indicates an infection .relatively sensitive temperature predictors of infection include: an increased temperature of at least 2 degrees Fahrenheit .a single temperature reading above 100 degree Fahrenheit .the nurse will identify, document and report to the physician any evidence of possible infectious complications . documents under Management Nursing staff will collaborate with the physician to distinguish individuals whose condition can be managed in the facility from those requiring hospital transfers .significantly unstable vital signs .may indicate possible need for hospitalization .documents under Monitoring and Follow-up Nursing staff will evaluate the progress of individuals with fever .until the symptoms resolve .the nurses will communicate with the physician by phone about resident status . Review of the facility's policy titled Notification/Change in a Resident's Condition or Status revised on 8/2018, documents our facility shall promptly notify the resident, his or her Attending Physician .of changes in the resident's medical /mental .condition .the nurse will notify the resident's Attending Physician or physician on call when there has been a .significant change in the resident's physical condition .a significant change of condition is a major decline .in the resident's status that will not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions .impacts more than one area of the resident's health status .the nurse will record in the resident's medical record information relative to changes in the residents medical/mental condition status . 1) Review of Resident #1's medical record documented an admission to the facility from an acute care facility on 02/05/20. The medical record documented [DIAGNOSES REDACTED]. Review of Resident #1's Health Status Note dated 02/19/20 17:30 documented resident in bed awake alert .skin warm and dry to touch .congestion noted, breathing treatment administered .oxygen 2 liters via nasal cannula in progress, vital signs: 101.5, 98, 20, 104/62, oxygen saturation 96%, safety and comfort maintained, call in reach, we will continue to monitor. Review of Resident #1's Orders-Administration Note dated 02/19/20 timed 17:33 documented Tylenol tablet 325 milligram (mg) give 2 tablets by mouth every 4 hours as needed for pain, fever .temperature greater than 101 . Review of Resident #1's Orders-Administration Note dated 02/19/20 timed 19:25 documented Tylenol tablet 325 mg- PRN (as needed) administration was effective . Review of Resident #1's Health Status Note dated 02/19/20 timed 20:50 documented Resident transfer to a local hospital via 911, MD (medical doctor) aware and resident family were here. Review of Resident #1's Health Status Note dated 02/19/20 timed 20:50 documented Resident in bed wake alert instead of going down resident T go from 101.5 to 102.9, and the BP (blood pressure) decrease from 104/62 to 61/48, O2 (oxygen) sat (saturation) 98% with oxygen at 2 liters via NC (nasal cannula), 911 called, awaiting arrival, staff at bedside. Review of Resident #1 Medication Administration Record [REDACTED]. Further review revealed lack of documentation for Resident #1's re-evaluation/follow up of physical status from 17:33 to 20:50. The medical record lacked documentation of the resident's temperature reading after administration of the Tylenol. Further review of Resident #4's medical records lacked evidence for notification of resident's significant change of a temperature of 101.5 at 17:33 to the physician. On 09/03/20 at 9:20 AM, an interview was conducted with Staff A, a Licensed Practical Nurse. Staff A stated that, if a resident developed any signs of distress, vital signs changes such a temperature, a change of status she would contact the physician. Staff A stated that if a resident developed a fever, she would administer Tylenol as per physician orders, apply cold compress, give fluids, recheck the resident's temperature 30 minutes after the Tylenol administration and call the doctor. Staff A added that if new orders were received, she would then proceed with the new orders. Staff A stated that she usually documented resident status and interventions on a health status note. On 09/03/20 at 2:26 PM, the Director of Nursing stated that on 02/19/20, Resident #1 had a temperature of 101.5, a breathing treatment and 2 Tylenol was given at 17:33 and that the Tylenol were effective per documentation at 19:25. The Director of Nursing was asked the meaning of Tylenol effective. The Director of Nursing stated that Tylenol effective means that the temperature was decreased. The surveyor asked for the resident's temperature after re-evaluation of the Tylenol administration and the Director of Nursing was not able to find any documentation of the resident's temperature in the related Tylenol effective documentation for 02/19/20 at 19:25. The Director of Nursing then stated that if a resident has a fever and is medicated, the nurses have to recheck the resident's temperature one hour after the resident had been medicated. The Director of Nursing stated that the nurse should have called the physician with Resident #1 temperature of 101.5 at 17:33. The Director of acknowledged the lack of documentation related to the resident change of condition and care from 17:33 to 20:50 when the resident was transferred out to the hospital. The Director of Nursing was unable to submit nursing documentation related Resident #1 change of condition notification to the physician on 02/19/20 at 17:33 or before 20:50. During the interview, the Director of Nursing

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) was asked to contact the nurse for Resident #1 on 02/19/20 at 17:33. The Director of Nursing stated that the nurse was not available for an interview. Review of Resident #1's temperature record history documentation revealed: 02/19/20 at 03:04 an axillary temperature of 98.4 02/19/20 at 08:22 a tympanic temperature of 96.9 02/19/20 at 17:33 an axillary temperature of 101.5 02/19/20 at 17:40 an axillary temperature of 101.5 02/19/20 at 20:16 an axillary temperature of 102.9 Further review the resident temperature reading history from 02/08/20 to 02/18/20 documented temperature readings range from 96.8 (02/10/20) to 98.6 (02/18/20) Fahrenheit degrees. Medical record documented a significant change of the resident's baseline temperature on 02/19/20 at 17:33. Review of the facility's assessment, communication and progress note titled SBAR (Situation, background, assessment, request) for Resident #1 dated 02/19/20 at 20:14 documented blood pressure 61/48; at 20:15 Pulse 112; Respirations 18; at 20:16 temperature 102.9-axilla; new or worsening behavioral symptoms; shortness of breath. The SBAR (B for background) information related to the resident's [MEDICAL CONDITION]/urine compared to baseline was not documented. The resident medical record documented a physician order [REDACTED]. Review of the facility transfer form lacked evidence of the resident's urinary catheter insertion date. Review of the resident's physician progress notes [REDACTED].denied any fever .no congestion .awake, alert and oriented to person, place, situation .appears in no distress .assessment- acute respiratory distress, [MEDICAL CONDITION]; plan-transfer to hospital . On 09/03/20 at 3:18 PM, during an interview, the Director of Nursing was asked to contact Resident #1 practitioner/provider. The Director of Nursing attempted to call the practitioner and stated that the Advanced Registered Nurse Practitioner (ARNP) was not available. On 09/03/20 at 3:26 PM, a second telephone call was made to the ARNP and a telephone interview was conducted. The ARNP stated that she vaguely remembered Resident #1. She stated that she is in the facility at different times of the day and did not recall if she was in the facility on 02/19/20 to evaluate Resident #1. The ARNP was asked if she had documentation related to a call from the facility's nurse regarding the resident's elevated temperature on 02/19/20. The ARNP stated that the nurses in the facility documented when they called her regarding a resident. The ARNP added that she does not keep documentation on residents and the new orders given to the facility's nurses .The ARNP was unable to confirm any communication with the facility's nurses on 02/19/20 between the hours of 17:33 to 20:50. 2) Review of Resident #4's medical record revealed an initial admission date of [DATE] and a readmission from an acute care hospital on [DATE]. Clinical [DIAGNOSES REDACTED]. Review of clinical records revealed a physician orders [REDACTED]. Review of the resident Treatment Administration Record (TAR) documented air mattress had been signed off by the nursing staff from 07/08/20 through 09/03/20. Review of the resident wound care telemedicine follow up evaluation dated 09/03/20 documented unstageable (due to necrosis) wound of the left heel with 100% necrotic tissue; wound progress-no change; continue with treatment plan. On 09/03/20 at 10:15 AM, observation and interview revealed Resident #4 in bed with blue boots on both feet .Resident # 4 stated that she has been turned from side to side and that her foot dressing was done. Resident #4 was unable to state if her mattress has been changed in the last two days. On 09/03/20 at 10:20 AM, Staff B, a Licensed Practical Nurse stated, she did Resident #4's left heel wound care a half an hour ago and added that she was not aware that she needed to wait for the surveyor to observe her during wound care. Staff B was asked to show Resident #4's left heel dressing. On 09/03/20 at 10:22 AM, a side by side observation of the resident with Staff B revealed both feet with boots and a dry clean dressing, dated 09/03/20 was noted on the resident's left heel. During the observation, Staff B was asked what kind of mattress Resident #4 had. Staff B stated that Resident #4 had a regular mattress. Staff B was asked if Resident # 4 was supposed to be on an air mattress and staff B responded yes. Staff B was unable to state a timeframe when asked how long Resident #4 has been without an air mattress. Staff B was apprised that she signed off that Resident #4 currently had an air mattress in place. Staff B stated that she did not realize that Resident #4 did not have the air mattress in place and further added that the resident was moved from another room but did not remember how long ago the change was done. On 09/03/20 at 1:38 PM, an interview was conducted with Staff C, a Certified Nursing Assistant, and stated that she did not notice that the Resident #4 did not have an air mattress in place during the morning care. Staff C stated that no one on duty today is familiar with the resident. On 09/03/20 at 1:40 PM, the Director of Nursing stated that a resident can get an air mattress the same day that it is ordered. The Director of Nursing was apprised that Resident #4 had a physician order [REDACTED].#4 had been without the air mattress. During the interview the Director of Nursing was asked multiple times to submit the facility policy related to following physician orders. On 09/03/20 at 2:05 PM, the Director of Nursing contacted the Wound care Nurse by telephone and a telephone interview was conducted. The Wound Care Nurse revealed during the telephone interview that, Resident #4's wound is stable and does not need an air mattress. The wound care nurse was apprised that Resident #4 has an order for [REDACTED].
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to implement all resident treatment, care and services consistent with the physician orders [REDACTED].#4) reviewed for pressure ulcers placing the resident at risk for potential worsening of the in-house acquired left heel pressure ulcer or the development of new pressure ulcers as evidenced by the lack of an air mattress for Resident #4. There were 6 residents with pressure ulcers out of 59 residents residing in the facility at the time of the survey. The findings included: Review of Resident #4 medical record revealed an initial admission date of [DATE] and a readmission from an acute care hospital on [DATE]. Clinical [DIAGNOSES REDACTED]. Review of Resident #4's medical record documented a physician orders [REDACTED]. Review of the resident treatment administration record documented air mattress and been signed off by the nursing staff from 07/08/20 through 09/03/20. Review of the resident wound care telemedicine follow up evaluation dated 09/03/20 documented unstageable (due to necrosis) wound of the left heel with 100% necrotic tissue; wound progress-no change; continue with treatment plan. On 09/03/20 at 10:15 AM, observation revealed Resident #4 in bed with blue boots on both feet. An interview was conducted with the resident and stated that she is been turned from side to side and that her foot dressing is been done. Resident #4 was unable to state if her mattress has been changed in the last two days. On 09/03/20 at 10:20 AM, an interview was conducted with Staff B, a Licensed Practical Nurse. Staff B stated that she did Resident #4 left heel wound care a half an hour ago and added that she was not aware that she needed to wait for the surveyor to observe her wound care. Staff B was asked to show Resident #4's left heel dressing. On 09/03/20 at 10:22 AM, a side by side observation of the resident with Staff B revealed both feet with boots and a dry clean dressing, dated 09/03/20 on the resident's left heel. During the observation, Staff B was asked what kind of mattress Resident #4 had and stated that she had a regular mattress. Staff B was asked if the resident was supposed to be on an air mattress and stated Yes. Staff B was asked how long Resident #4 has been without an air mattress and she was unable to state a timeframe. Staff B was apprised that she signed off that the resident has currently an air mattress in place. Staff B stated that she did not realize that Resident #4 did not have the air mattress in place. On 09/03/20 at 1:38 PM, an interview was conducted with Staff C, a Certified Nursing Assistant, and stated that she did not notice that the Resident #4 did not have an air mattress in place during the morning care. Staff C stated that no one on duty today is familiar with the resident. On 09/03/20 at 1:40 PM, the Director of Nursing and stated that a resident can get an air mattress the same day it is ordered. The Director of Nursing was apprised that Resident #4 had a physician order [REDACTED]. She stated that she was not sure how long was the resident without the air mattress. During the interview the Director of Nursing was asked multiple times to submit the facility policy related to following new physician orders. On 09/03/20 at 2:05 PM, during a telephone interview the wound care nurse stated Resident #4 wound is stable and does not need an air mattress, The wound care nurse was apprised that Resident #4 has an order for [REDACTED]. On 09/03/20 at 4:35 PM, the Director for Nursing submitted the facility policy related to admission orders [REDACTED].
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to accurately document assessments and care provided after an elevated axillary temperature from 101.5 degrees Fahrenheit (F) to 102.9 degrees Fahrenheit for 1 out of 3 residents reviewed (Resident #1) as evidenced by: the lack of follow up assessment documentation in clinical records after an elevated axillary temperature of 101.5 degrees Fahrenheit and failed to accurately documented resident significant change from baseline as evidenced of an elevated temperature (Resident #1); failed to accurately document resident care consistent with the physician orders [REDACTED].#4) reviewed for pressure ulcer as evidenced by the nursing staff signing off for an air mattress for Resident #4 that was lacking an air mattress that was ordered by the physician and was never

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F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) placed on the bed for Resident #4. The findings included: Review of the facility's policy titled Fever/[MEDICAL CONDITION]-Clinical Protocol undated, documents under Assessment/Evaluation/Recognition A nurse will assess a resident with a suspected infection and will document related findings .the nurse will report findings to the physician .the nurse will discuss with the physician whether a temperature elevation .presence of a fever indicates an infection .relatively sensitive temperature predictors of infection include: an increased temperature of at least 2 degrees Fahrenheit .a single temperature reading above 100 degree Fahrenheit .the nurse will identify, document and report to the physician any evidence of possible infectious complications . documents under Management Nursing staff will collaborate with the physician to distinguish individuals whose condition can be managed in the facility from those requiring hospital transfers .significantly unstable vital signs .may indicate possible need for hospitalization .documents under Monitoring and Follow-up Nursing staff will evaluate the progress of individuals with fever .until the symptoms resolve .the nurses will communicate with the physician by phone about resident status . Review of the facility's policy titled Notification/Change in a Resident's Condition or Status revised on 8/2018, documents our facility shall promptly notify the resident, his or her Attending Physician .of changes in the resident's medical /mental .condition .the nurse will notify the resident's Attending Physician or physician on call when there has been a .significant change in the resident's physical condition .a significant change of condition is a major decline .in the resident's status that will not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions .impacts more than one area of the resident's health status .the nurse will record in the resident's medical record information relative to changes in the residents medical/mental condition status . 1) Review of Resident #1's medical records documented an admission to the facility from an acute care facility on 02/05/20. The medical record documented [DIAGNOSES REDACTED]. Review of Resident #1's Health Status Note dated 02/19/20 17:30 documented resident in bed awake alert .skin warm and dry to touch .congestion noted, breathing treatment administered .oxygen 2 liters via nasal cannula in progress, vital signs: 101.5, 98, 20, 104/62, oxygen saturation 96%, safety and comfort maintained, call in reach, we will continue to monitor. Review of Resident #1's Orders-Administration Note dated 02/19/20 timed 17:33 documented Tylenol tablet 325 mg- give 2 tablets by mouth every 4 hours as needed for pain, fever .temperature greater than 101 . Review of Resident #1's Orders-Administration Note dated 02/19/20 timed 19:25 documented Tylenol tablet 325 mg- PRN (as needed) administration was effective . Review of Resident #1's Health Status Note dated 02/19/20 timed 20:50 documented Resident transfer to a local hospital via 911, MD (medical doctor) aware and resident family were here. Review of Resident #1's Health Status Note dated 02/19/20 timed 20:50 documented Resident in bed wake alert instead of going down resident T go from 101.5 to 102.9, and the BP (blood pressure) decrease from 104/62 to 61/48, O2 (oxygen) sat (saturation) 98% with oxygen at 2 liters via NC (nasal cannula), 911 called, awaiting arrival, staff at bedside. Review of Resident #1's Medication Administration Record [REDACTED]. Further review revealed lack of documentation of Resident #1's re-evaluation/follow up of physical status from 17:33 to 20:50. The medical record lacked documentation of the resident temperature reading after administration of Tylenol. Furthermore, the medical record lacked evidence of notification indicating the resident's significant change in temperature of 101.5 at 17:33 to the physician. On 09/03/20 at 9:20 AM, Staff A, a Licensed Practical Nurse, stated that the physician should be called if a resident developed any signs of distress, vital signs changes such as temperature, a change of status. Staff A stated that if a resident develops a fever, she would administer Tylenol as per physician orders, apply cold compress, give fluids, recheck the resident's temperature 30 minutes after the Tylenol administration and call the doctor. Staff A added that if new orders are received, she would proceed with new orders. Staff A stated that she would document the resident's status and interventions on a health status note. On 09/03/20 at 2:26 PM, the Director of Nursing stated that on 02/19/20, Resident #1 had a temperature of 101.5, a breathing treatment and 2 Tylenol were given at 17:33 and that the Tylenol's were effective per documentation at 19:25. The Director of Nursing was asked what Tylenol effective means, the Director of nursing stated that meant the temperature was decreased. The Director of Nursing was asked for the resident's temperature after re-evaluation of the Tylenol administration and she was not able to find documentation related Tylenol effective documented at 19:25. The Director of Nursing stated that if a resident has a fever and is medicated, the nurses should have rechecked the resident's temperature one hour after been medicated. The Director of Nursing stated that the nurse should have called the physician with Resident #1's temperature of 101.5 at 17:33. The Director of Nursing confirmed the lack of documentation related to the resident's change of condition and care from 17:33 to 20:50 when the resident was transferred out to the hospital. The Director of Nursing was unable to provide any nursing documentation related Resident #1's change of condition notification to the physician on 02/19/20 at 17:33 or before 20:50. During the interview, the Director of Nursing was asked to contact the nurse for Resident #1 on 02/19/20 at 17:33 and the Director of Nursing stated that the nurse was not available for an interview. Review of Resident #1's temperature record history documentation revealed: 02/19/20 at 03:04 an axillary temperature of 98.4 02/19/20 at 08:22 a tympanic temperature of 96.9 02/19/20 at 17:33 an axillary temperature of 101.5 02/19/20 at 17:40 an axillary temperature of 101.5 02/19/20 at 20:16 an axillary temperature of 102.9 Further review the resident temperature reading history from 02/08/20 to 02/18/20 documented temperature readings range from 96.8 (02/10/20) to 98.6 (02/18/20) Fahrenheit degrees. Medical record documented a significant change of the resident's baseline temperature on 02/19/20 at 17:33. Review of the facility's assessment, communication and progress note titled SBAR (Situation, background, assessment, request) for Resident #1 dated 02/19/20 at 20:14 documented blood pressure 61/48; at 20:15 Pulse 112; Respirations 18; at 20:16 temperature 102.9-axilla; new or worsening behavioral symptoms; shortness of breath. The SBAR (B for background) information related to the resident's [MEDICAL CONDITION]/urine compared to baseline was not documented. The resident medical record documented a physician order [REDACTED]. Review of the facility's transfer form lacked evidence of the resident's urinary catheter insertion date. Review of the resident's physician progress notes [REDACTED].denied any fever .no congestion .awake, alert and oriented to person, place, situation .appears in no distress .assessment- acute respiratory distress, [MEDICAL CONDITION]; plan-transfer to hospital . On 09/03/20 at 3:18 PM, during an interview, the Director of Nursing was asked to contact Resident #1's practitioner/provider. The Director of Nursing attempted to call the practitioner and stated that the Advance Registered Nurse Practitioner (ARNP) was not available. On 09/03/20 at 3:26 PM, a second telephone call was made to the resident ARNP. The ARNP stated during the telephone interview that she vaguely remembered Resident #1. The ARNP explained that she is in the facility at different times of the day and did not recall if she was in the facility on 02/19/20 to evaluate Resident #1. The ARNP was asked if she had documentation related to a call from the facility's nurse regarding Resident #1's elevated temperature on 02/19/20 as indicated in the facility's document. The ARNP stated that she does not keep documentation on residents and new orders given to the facility nurses. The ARNP was unable to confirm communication with the facility's nurses on 02/19/20 between the hours of 17:33 to 20:50. 2)Review of Resident #4's medical record revealed an initial admission date of [DATE] and a readmission from an acute care hospital on [DATE]. Clinical [DIAGNOSES REDACTED]. Review of Resident #4's medical record documented a physician orders [REDACTED]. Review of the resident treatment administration record documented air mattress and had been signed off by the nursing staff from 07/08/20 through 09/03/20. Review of the resident's wound care telemedicine follow up evaluation dated 09/03/20 documented unstageable (due to necrosis) wound of the left heel with 100% necrotic tissue; wound progress-no change; continue with treatment plan. On 09/03/20 at 10:15 AM, observation and interview revealed Resident #4 in bed with blue boots on both feet. Resident #4 and stated that she is been turned from side to side and that her foot dressing was done. Resident # 4 was unable to state if her mattress had been changed within the last two days. On 09/03/20 at 10:20 AM, an interview was conducted with Staff B, a Licensed Practical Nurse. Staff B stated that she did Resident #4's left heel wound care a half an hour ago and added that she was not aware that she needed to wait for the surveyor to observe her wound care. Staff B was asked to show Resident #4's left heel dressing. On 09/03/20 at 10:22 AM, a side by side observation of Resident #4 with Staff B revealed both feet with boots and a dry clean dressing, dated 09/03/20 on the resident's left heel. During the observation, Staff B was asked what kind of mattress Resident #4 had. Staff B stated that Resident #4 had a regular mattress. Staff B was asked if the resident was supposed to be on an air mattress, Staff B stated Yes. Staff B asked how long Resident #4 has been without an air mattress. Staff B was unable to state a timeframe that Resident #4 has been without an air mattress. Staff B was apprised that she (Staff B)signed off that Resident #4 currently had an air mattress in place. Staff B stated that she did not realize that Resident #4 did not have the air mattress in place. On 09/03/20 at 1:38 PM, Staff C, a Certified Nursing Assistant, stated that she did not notice that Resident #4 did not have an air mattress in place during the morning care. Staff C stated that no one on duty today is familiar with the resident. On 09/03/20 at 1:40 PM, the Director of Nursing stated that a resident can get an air mattress the same day that it is ordered. The Director of Nursing was apprised that Resident #4 had a physician order [REDACTED]. During the interview the Director of Nursing was asked multiple times to submit the facility policy related to following

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105153	A. BUILDING _____ B. WING _____	**09/03/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PINECREST REHABILITATION CENTER	**13650 NE 3RD COURT NORTH MIAMI, FL 33161**

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 4) new physician orders. On 09/03/20 at 2:05 PM, a telephone interview was conducted with the wound care nurse. The Wound Care nurse stated Resident #4's wound is stable and does not need an air mattress. The wound care nurse was apprised that resident #4 has an order for [REDACTED].