STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105653	A. BUILDING _____ B. WING _____	**08/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CONSULATE HEALTH CARE OF ORANGE PARK	**1215 KINGSLEY AVE ORANGE PARK, FL 32073**

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 0658 **Level of harm -** Actual harm **Residents Affected -** Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff interviews, the facility failed to provide care and services which met professional standards of quality by failing to ensure all newly admitted residents were appropriately assessed and observed for changes in condition. It failed to ensure the review of all pertinent information provided by the hospital at the time of admission, including medications for one (Resident #1) of three sampled residents, and it failed to ensure the appropriate administration of medication (anticoagulant) as ordered for one (Resident #2) of three sampled residents. The facility's failure to complete physical assessments, including those for changes in condition, and its failure to ensure a review of hospital records provided upon admission, which included a need for continued use of anticoagulant medication, contributed to the formation of a blood clot in Resident #1's leg, necessitating further hospitalization to remove it. Professional standards of quality means that care and services are provided according to accepted standards of clinical practice. Standards may apply to care provided by a particular clinical discipline or in a specific clinical situation or setting. The Florida Nurse Practice Act, Chapter 464.003 defines the practice of professional nursing as, The performance of those acts requiring substantial specialized knowledge, judgment and nursing skill based upon applied principles of psychological, biological, physical and social sciences, which shall include but is not limited to: the administration of medications and treatments as prescribed or authorized by a duly licensed practitioner. The practice of practical nursing is the performance of selected acts, including the administration of treatments and medications in the care of the ill, injured or infirmed and the promotion of wellness, maintenance or health, and the prevention of illness of others under the direction of a registered nurse, a licensed physician, a licensed osteopathic physician or a licensed dentist. The findings include: 1. A review of the clinical record revealed that Resident #1 was hospitalized from [DATE] through 7/27/20. She underwent left hip surgery on 7/17/20 and on 7/23/20, she underwent surgery to the right malleolus (ankle) and left ulna (forearm). Due to extensive leg injuries she was non-weight bearing on both legs. During her hospital stay she was ordered [MEDICATION NAME] (blood thinner) 30 mg (milligrams) twice daily to prevent blood clots. Upon discharge she was ordered dressing changes to the left hip, left arm and right lower leg. She was to wear a hinged knee brace to the left leg at all times. She was to receive physical and occupational therapy (PT, OT) and remain non-weight bearing for four weeks. She was also ordered [MEDICATION NAME] (opioid pain medication) every 12 hours. A review of Resident #1's hospital record, provided to the facility by the hospital upon the resident's nursing home admission, revealed the following: On 7/27/20, Resident #1 was seen by the trauma Advanced Practice Registered Nurse (APRN) for discharge orders. The orders included: Follow up with the orthopedic surgeon in one week for suture removal, PT and OT daily, non-weight bearing x 4 weeks, pain control, regular diet, maintain dressings clean and dry to all sites, and [MEDICATION NAME] 40 mg twice daily to prevent [MEDICAL CONDITION] ([MEDICAL CONDITION] - blood clot). Also, on 7/27/20 the hospitalist working with the APRN documented that he reviewed the resident's history, personally evaluated the resident and agreed with the APRN's assessment and plan. The addendum included [MEDICATION NAME]. A review of the surgeon's note dated 7/27/20, included the following instructions: Pain control, regular diet, non-weight bearing right and left leg, five pound weight bearing for left upper arm, elevate left upper arm and right lower leg, PT and OT, [MEDICAL CONDITION] (prevention) and [MEDICATION NAME] 40 mg twice daily. A review of the Admission Data Collection form dated 7/28/20, revealed there was no time of data collection recorded, it did not include vital signs, surgical dressings in place, multiple fractures, knee immobilizer in place or a pain assessment. There were no initial nursing notes or a physical assessment. Further review of the record revealed that upon admission on 7/28/20, Registered Nurse (RN) A completed a medication reconciliation form. The form was to be completed by utilizing the following data sources (check all that apply): History and Physical, Discharge Summary, previous medication administration records (MAR) and interview with resident/resident representative. Part 1 of the form: The nurse checked off that she reviewed the hospital History and Physical and Discharge Summary. Part 2 of the form: List medications needing clarification. RN A checked No medication issues identified. Part 3 of the form: Physician contact. RN A documented the physician's name but not that the physician was notified. Had the hospital records been reviewed per the form's instructions, RN A would have been aware of the need for [MEDICATION NAME] (blood thinner) and the need to report the findings to the physician. A review of the nursing notes for 7/29/20 and 7/30/20 lacked any physical assessments including surgical sites, circulation or physical changes of the extremities due to multiple fractures. Further review of the record found no nursing notes or assessments for 7/31/20 or 8/1/20. The nursing documentation for 8/2/20 found no physical assessments recorded. The nursing note dated 8/3/20 on the 11PM to 7AM shift, revealed no documentation of a change in condition related to the resident's left leg. There were no nursing notes completed or assessments performed for the 7AM to 3PM or 3PM to 11PM shifts on 8/3/20 related to the change of condition warranting a Doppler study of the left leg. A physician's orders [REDACTED]. Results of the Doppler study revealed an occlusive venous [MEDICAL CONDITION] (blood clot) of the left leg. An order was found on 8/3/20 for Eliquis (anticoagulant - blood thinner) 5 mg twice daily during a review of the physician's orders [REDACTED]. The first dose was not administered until 9AM on 8/4/20. Resident #1 was at very high risk for development of blood clots related to recent traumatic injuries from a motor vehicle accident (MVA) that resulted in multiple fractures requiring surgery to repair her left hip, right malleolus and left ulna. Due to the extensive injuries and significant pain associated with those injuries, she was unable to move or reposition herself. She was also bed-bound due to her non-weight bearing status on both legs. This inability to move put her at greater risk of developing a blood clot. There was no nursing note or physical assessment for 8/4/20. A review of the transfer sheet for transport to the hospital, dated 8/4/20 at 4:56PM gave no reason for the transfer or notification of Resident #1's family. Resident #1 was admitted to the hospital on [DATE] and underwent surgery to remove the blood clot in her left leg. During an interview with the interim Director of Nursing (DON) on 8/17/20 at 1:30PM, she was asked if there were nursing notes for Resident #1 on 7/31/20, 8/1/20, 8/3/20 or 8/4/20. She stated she would check with the Medical Records Department. When she returned, she said she was told everything the resident had on file was in the record. She was asked whether the nurses documented every shift on residents who were receiving skilled services. She said, Usually once a day and more if there were changes or new orders. She was asked if there were daily skilled nursing (SN) notes for Resident #1. After a review of the notes, she stated the record was incomplete and no skilled nursing notes had been recorded for several days. She was asked if any of the notes in the chart reflected a change in condition or a need to transfer Resident #1 to the hospital and she replied no. The DON was also asked if the medication reconciliation form (MRF) was to be signed by the physician, and she replied no, it was a tool for the nurses. She was asked to review the MRF for Resident #1, dated 7/28/20. When asked if the nurse checked off that she had reviewed the hospital records, the DON said yes. She was asked whether the nurse documented any reference from the hospital physicians for the continued need for [MEDICATION NAME]. She said not that she could find. An interview was conducted with the Regional Director of Clinical Services at 4:20PM. She was asked if there was a policy regarding the medication reconciliation form. She said she would look. At 4:38PM, she reported there was no policy regarding medication reconciliation; it was included in the Admission Assessment policy. A review of the Admission Assessment policy revealed

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0658 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 1) the following: At the time of admission or readmission the nurse shall initiate the data collection forms. 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. According to RxList at https://www.rxlist.com/[MEDICATION NAME]-side-effects-drug-center.html: [MEDICATION NAME] ([MEDICATION NAME] sodium) Injection is an anticoagulant (blood thinner) used to prevent blood clots that are sometimes called [MEDICAL CONDITIONS], which can lead to blood clots in the lungs. A [MEDICAL CONDITION] can occur after certain types of surgery, or in people who are bed-ridden due to a prolonged illness. Obese patients are at higher risk for [MEDICAL CONDITION]. According to Healthline at https://www.healthline.com/health/[MEDICATION NAME]-injectable-solution: [MEDICATION NAME] is used to thin your blood. It keeps your blood from forming clots. Blood clots are dangerous because they can lead to serious blockages in your blood vessels. This can cause a stroke or a [MEDICAL CONDITION]. This drug is used to prevent blood clots in people who are hospitalized . It may be used if you 're too sick to move around. It ' s also used to prevent blood clots at home after you ' ve had stomach surgery or a hip or knee replacement. This drug is also used to treat existing blood clots in the hospital or at home. If you stop taking the drug suddenly or don ' t take it at all: You ' ll have a higher risk for a blood clot. This could lead to serious problems, such as a stroke or death. Take this drug on the schedule set by your doctor. Don ' t stop taking it without speaking with your doctor first. 2. A record review for Resident #2 revealed a [AGE] year-old female admitted on [DATE] with [DIAGNOSES REDACTED]. She was documented as alert with confusion. A review of the admitting medication orders revealed they included [MEDICATION NAME] (anticoagulant) 30 mg daily for 3 days. A review of the July 2020 MARs revealed that [MEDICATION NAME] 30 mg was ordered to be administered at 9AM on 7/29/20, 7/30/20 and 7/31/20. On 7/29/20, the medication was circled, indicating it was not administered. On 7/31/20, the medication was not signed off as having been administered; it was left blank. Resident #2 missed two of three doses ordered. An interview was conducted with the Director of Nursing (DON) at 5:50PM. She was asked to review the MAR for the administration of [MEDICATION NAME]. She confirmed that on 7/29/20, the circled initial indicated an omission or indication the medication was not available. She would expect a note on the back of the MAR indicated [REDACTED]. When asked if the physician had been notified of the missed doses, she said there was no verification of that, as it had not been noted on the MAR. She further added the physician should have been notified and an order requested to continue the medication to ensure the resident received three doses. A review of the admission records revealed the Admission Data Collection form for 7/28/20 was blank. There was no admission assessment or initial nursing note. (Photographic evidence obtained) A review of the daily skilled nursing notes found entries for 7/29/20, 7/30/20 and 8/3/20. There was no documentation of physical assessments or vital signs having been completed on 8/1/20 or 8/2/20. On 8/30/20, Resident #1 was found unresponsive at 9:15AM. Her pulse was thready (barely audible), her oxygen saturation level was not reading on the pulse oximeter, her oxygen was administered at 5 liters per minute and then increased to 90% saturation. Emergency Medical Services (EMS) was called, and she was more responsive when paramedics arrived. She was transferred to the hospital. During an interview with the Regional Nurse Consultant at 3:50 PM on 8/17/20, she was asked about the time frame for completing the Admission Assessment. She stated the expectation was that the admitting nurse would complete the assessment within two to four hours of admission. She was asked to review the assessment and she confirmed that the form was blank. The admitting nurse did not even sign it. She confirmed that the admission assessment had not been completed for this resident. According to the Mayo Clinic at https://www.mayoclinic.org/diseases-conditions/[MEDICAL CONDITION]-fibrillation/symptoms-causes/syc- 624 on 8/17/20: A major concern with [MEDICAL CONDITION] is the potential to develop blood clots within the upper chambers of the heart. These blood clots forming in the heart may circulate to other organs and lead to blocked blood flow (ischemia). According to Drugs.com at https://www.drugs.com/[MEDICATION NAME].html: [MEDICATION NAME] ([MEDICATION NAME]) is an anticoagulant that helps prevent the formation of blood clots. . .
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** Based on record reviews and staff interviews, the facility failed to provide care and treatment in accordance with professional standards of practice, by failing to ensure all newly admitted residents were appropriately assessed, including reconciliation of medications with hospital discharge records for one (Resident #1) of three sampled residents. The facility also failed to ensure anticoagulant medication (blood thinning medication) was administered as ordered for one (Resident #2) of three sampled residents. The facility's failure to complete physical assessments, including those for changes in condition, and its failure to ensure a review of hospital records provided upon admission, which included a need for continued use of anticoagulant medication, contributed to the formation of a blood clot in Resident #1's leg, necessitating further hospitalization to remove it. The findings include: 1.A review of Resident #1's clinical record revealed a [AGE] year-old female admitted on [DATE] with [DIAGNOSES REDACTED]. Resident #1 was hospitalized from [DATE] through 7/27/20. She underwent left hip surgery on 7/17/20 and on 7/23/20, she underwent surgery to the right malleolus (ankle) and left ulna (forearm). Due to extensive leg injuries she was non-weight bearing on both legs. During her hospital stay she was ordered [MEDICATION NAME] (blood thinner) 30 mg (milligrams) twice daily to prevent blood clots. Upon discharge she was ordered dressing changes to the left hip, left arm and right lower leg. She was to wear a hinged knee brace to the left leg at all times. She was to receive physical and occupational therapy (PT, OT) and remain non-weight bearing for four weeks. She was also ordered [MEDICATION NAME] (opioid pain medication) every 12 hours. A review of Resident #1's hospital record, provided to the facility by the hospital upon the resident's nursing home admission, revealed the following: On 7/27/20, Resident #1 was seen by the trauma Advanced Practice Registered Nurse (APRN) for discharge orders. The orders included: Follow up with the orthopedic surgeon in one week for suture removal, PT and OT daily, non-weight bearing x 4 weeks, pain control, regular diet, maintain dressings clean and dry to all sites, and [MEDICATION NAME] 40 mg twice daily to prevent [MEDICAL CONDITION] ([MEDICAL CONDITION] - blood clot). Also, on 7/27/20 the hospitalist working with the APRN documented that he reviewed the resident's history, personally evaluated the resident and agreed with the APRN's assessment and plan. The addendum included [MEDICATION NAME]. A review of the surgeon's note dated 7/27/20, included the following instructions: Pain control, regular diet, non-weight bearing right and left leg, five pound weight bearing for left upper arm, elevate left upper arm and right lower leg, PT and OT, [MEDICAL CONDITION] (prevention) and [MEDICATION NAME] 40 mg twice daily. A review of the Admission Data Collection form dated 7/28/20, revealed there was no time of data collection recorded, it did not include vital signs, surgical dressings in place, multiple fractures, knee immobilizer in place or a pain assessment. There were no initial nursing notes or a physical assessment. Further review of the record revealed that upon admission on 7/28/20, Registered Nurse (RN) A completed a medication reconciliation form. The form was to be completed by utilizing the following data sources (check all that apply): History and Physical, Discharge Summary, previous medication administration records (MAR) and interview with resident/resident representative. Part 1 of the form: The nurse checked off that she reviewed the hospital History and Physical and Discharge Summary. Part 2 of the form: List medications needing clarification. RN A checked No medication issues identified. Part 3 of the form: Physician contact. RN A documented the physician's name but not that the physician was notified. Had the hospital records been reviewed per the form's instructions, RN A would have been aware of the need for [MEDICATION NAME] (blood thinner) and the need to report the findings to the physician. A review of the nursing notes for 7/29/20 and 7/30/20 lacked any physical assessments including surgical sites, circulation or physical changes of the extremities due to multiple fractures. Further review of the record found no nursing notes or assessments for 7/31/20 or 8/1/20. The nursing documentation for 8/2/20 found no physical assessments recorded. The nursing note dated 8/3/20 on the 11PM to 7AM shift, revealed no documentation of a change in condition related to the resident's left leg. There were no nursing notes completed or assessments performed for the 7AM to 3PM or 3PM to 11PM shifts on 8/3/20 related to the change of condition warranting a Doppler study of the left leg. A physician's orders [REDACTED]. Results of the Doppler study revealed an occlusive venous [MEDICAL CONDITION] (blood clot) of the left leg. An order was found on 8/3/20 for Eliquis (anticoagulant - blood thinner) 5 mg twice daily during a review of the physician's orders [REDACTED]. The first dose was not administered until 9AM on 8/4/20. Resident #1 was at very high risk for development of blood clots related to recent traumatic injuries from a motor vehicle accident (MVA) that resulted in multiple fractures requiring surgery to repair her left hip, right malleolus and left ulna. Due to the extensive injuries and significant pain associated with those injuries, she was unable to move or reposition herself. She was also bed-bound due to her non-weight bearing status on both legs. This inability to move put her at greater risk of

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F 0684 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 2) developing a blood clot. There was no nursing note or physical assessment for 8/4/20. A review of the transfer sheet for transport to the hospital, dated 8/4/20 at 4:56PM gave no reason for the transfer or notification of Resident #1's family. Resident #1 was admitted to the hospital on [DATE] and underwent surgery to remove the blood clot in her left leg. During an interview with the interim Director of Nursing (DON) on 8/17/20 at 1:30PM, she was asked if there were nursing notes for Resident #1 on 7/31/20, 8/1/20, 8/3/20 or 8/4/20. She stated she would check with the Medical Records Department. When she returned, she said she was told everything the resident had on file was in the record. She was asked whether the nurses documented every shift on residents who were receiving skilled services. She said, Usually once a day and more if there were changes or new orders. She was asked if there were daily skilled nursing (SN) notes for Resident #1. After a review of the notes, she stated the record was incomplete and no skilled nursing notes had been recorded for several days. She was asked if any of the notes in the chart reflected a change in condition or a need to transfer Resident #1 to the hospital and she replied no. The DON was also asked if the medication reconciliation form (MRF) was to be signed by the physician, and she replied no, it was a tool for the nurses. She was asked to review the MRF for Resident #1, dated 7/28/20. When asked if the nurse checked off that she had reviewed the hospital records, the DON said yes. She was asked whether the nurse documented any reference from the hospital physicians for the continued need for [MEDICATION NAME]. She said not that she could find. An interview was conducted with the Regional Director of Clinical Services at 4:20PM. She was asked if there was a policy regarding the medication reconciliation form. She said she would look. At 4:38PM, she reported there was no policy regarding medication reconciliation; it was included in the Admission Assessment policy. A review of the Admission Assessment policy revealed the following: At the time of admission or readmission the nurse shall initiate the data collection forms. 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. 2. A record review for Resident #2 revealed a [AGE] year-old female admitted on [DATE] with [DIAGNOSES REDACTED]. She was documented as alert with confusion. A review of the admitting medication orders revealed they included [MEDICATION NAME] (anticoagulant) 30 mg daily for 3 days. A review of the July 2020 MARs revealed that [MEDICATION NAME] 30 mg was ordered to be administered at 9AM on 7/29/20, 7/30/20 and 7/31/20. On 7/29/20, the medication was circled, indicating it was not administered. On 7/31/20, the medication was not signed off as having been administered; it was left blank. Resident #2 missed two of three doses ordered. An interview was conducted with the Director of Nursing (DON) at 5:50PM. She was asked to review the MAR for the administration of [MEDICATION NAME]. She confirmed that on 7/29/20, the circled initial indicated an omission or indication the medication was not available. She would expect a note on the back of the MAR indicated [REDACTED]. When asked if the physician had been notified of the missed doses, she said there was no verification of that, as it had not been noted on the MAR. She further added the physician should have been notified and an order requested to continue the medication to ensure the resident received three doses. A review of the admission records revealed the Admission Data Collection form for 7/28/20 was blank. There was no admission assessment or initial nursing note. (Photographic evidence obtained) A review of the daily skilled nursing notes found entries for 7/29/20, 7/30/20 and 8/3/20. There was no documentation of physical assessments or vital signs having been completed on 8/1/20 or 8/2/20. On 8/30/20, Resident #1 was found unresponsive at 9:15AM. Her pulse was thready (barely audible), her oxygen saturation level was not reading on the pulse oximeter, her oxygen was administered at 5 liters per minute and then increased to 90% saturation. Emergency Medical Services (EMS) was called, and she was more responsive when paramedics arrived. She was transferred to the hospital. During an interview with the Regional Nurse Consultant at 3:50 PM on 8/17/20, she was asked about the time frame for completing the Admission Assessment. She stated the expectation was that the admitting nurse would complete the assessment within two to four hours of admission. She was asked to review the assessment and she confirmed that the form was blank. The admitting nurse did not even sign it. She confirmed that the admission assessment had not been completed for this resident. .
F 0711 **Level of harm** - Actual harm **Residents Affected** - Few	**Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff and physician interview, the facility failed to ensure the physician reviewed the resident's total program of care, including medications and treatments, by failing to ensure that after a recent hospitalization , the attending physician reviewed the hospital discharge summary and hospital progress notes received upon the admission of one (Resident #1) of three sampled residents. Failure to review this documentation, which explained the need for continued anticoagulant medication, contributed to the development of a blood clot in Resident #1's leg, necessitating her return to the hospital for surgical removal of the clot. The findings include: A review of Resident #1's clinical record revealed a [AGE] year-old female admitted on [DATE] with [DIAGNOSES REDACTED]. Resident #1 was hospitalized from [DATE] through 7/27/20. She underwent left hip surgery on 7/17/20 and on 7/23/20, she underwent surgery to the right malleolus (ankle) and left ulna (forearm). Due to extensive leg injuries she was non-weight bearing on both legs. During her hospital stay she was ordered [MEDICATION NAME] (blood thinner) 30 mg (milligrams) twice daily to prevent blood clots. Upon discharge she was ordered dressing changes to the left hip, left arm and right lower leg. She was to wear a hinged knee brace to the left leg at all times. She was to receive physical and occupational therapy (PT, OT) and remain non-weight bearing for four weeks. She was also ordered [MEDICATION NAME] (opioid pain medication) every 12 hours. A review of Resident #1's hospital record, provided to the facility by the hospital upon the resident's nursing home admission, revealed the following: On 7/27/20 while hospitalized , Resident #1 was seen by the trauma Advanced Practice Registered Nurse (APRN) for discharge orders. The orders included: Follow up with the orthopedic surgeon in one week for suture removal, physical and occupational therapy daily, non-weight bearing for four weeks, pain control, regular diet, maintain dressings clean and dry to all sites, and [MEDICATION NAME] 40 mg (milligrams)twice daily to prevent [MEDICAL CONDITION] ([MEDICAL CONDITION] - blood clot). Also, on 7/27/20 the hospitalist working with the APRN documented that he reviewed the resident's history, personally evaluated the resident and agreed with the APRN's assessment and plan. The addendum included [MEDICATION NAME]. A review of the surgeon's note, dated 7/27/20 (the day before the resident was discharged from the hospital and admitted to the facility), included the following instructions: Pain control, regular diet, non-weight bearing right and left leg, five pound weight bearing for left upper arm, elevate left upper arm and right lower leg, PT and OT, [MEDICAL CONDITION] (prevention) and [MEDICATION NAME] 40 mg twice daily. A review of the medication list sent from the hospital, revealed it did not include an order for [REDACTED]. Also included was Do not stop taking except on the advise of your physician. An interview was conducted with the attending physician for Resident #1 on 8/17/20 at 1:40 pm. He was asked if he had treated Resident #1 when she was at the facility. He said yes, she had been in a motor vehicle accident (MVA) with multiple fractures. When asked why she had been transferred to the hospital on [DATE] he stated she had developed a blood clot in her leg. He was asked if he had ordered anticoagulant (blood thinner) medication upon admission, and he stated he ordered Eliquis after a Doppler study revealed a blood clot in her leg. When asked whether she had received the Eliquis, he stated he did not know but said she did go to the hospital the day after the Doppler. He was asked whether he was aware that Resident #1 was taking [MEDICATION NAME] during her hospital stay and that two physicians and an APRN documented on 7/27/20 (the day before admission to the facility) that she needed to continue the [MEDICATION NAME]. He said he did not recall if he saw her or his partner saw her, but it would be in the progress notes. He was asked if he had reviewed the hospital discharge records, and he stated he would need to refer to the progress notes. When asked where he documented his progress notes, he stated they were dictated and brought to the facility to be filed in the record. He was informed that there were no physician's progress notes in the the resident's clinical record (20 days after the resident's admission). He stated he would contact his office and have the notes sent to the facility via e-mail so they would be available. He further stated that in his notes, or if it was his partner that saw her, in their notes, there would be a reference to the hospital records and any need for an anticoagulant. During an interview with the Administrator on 8/17/20 at 2:15 pm, she was asked if she had received the physician's progress notes for Resident #1. She said she had not yet received them, but would provide them as soon as the email arrived. She was asked again at 3:30 pm and 4:30 pm, and said she would call the physician's office to find out where they were. At the time of the exit conference (6:15 pm), the progress notes had not been provided. The Administrator emailed the physician's progress notes to the field office on 8/21/20 at 4:30 pm (four days after the survey exit). A review of the progress notes revealed that physician visits were made on 7/29/20, 7/31/20 and a telehealth visit was conducted on 8/3/20. A review of the visit note for 7/29/20, revealed the physician documented there were no current medications or allergies on file and an examination had been performed. The

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F 0711 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 3) resident was noted as an obese female lying in bed at the time of the assessment. She was noted with left upper and lower immobilizers in place. The visit assessment/[DIAGNOSES REDACTED]. Deconditioning, physical and occupational therapy ordered and she had been in a motor vehicle accident with multiple fractures. The visit summary/care plan addressed constipation with laxative medication, it addressed pain with pain medication and it noted: MVA resulting in multiple fractures, patient with a follow up appointment with the hospital physician on 8/10/20. Physical deconditioning with therapy ordered. Monitor the resident's temperature daily, continue with therapy, follow up with hospital orthopedic team, and facility nursing staff was to notify the provider of abnormal lab work or any changes in condition. There was no documentation indicating that the hospital history and physical (H&P) and discharge summary, indicating an ongoing need for [MEDICATION NAME], were reviewed by the attending physician. There was no mention of anticoagulant use. A review of the visit note for 7/31/20, revealed that an examination was performed, and allergies/medications were reviewed from the resident's facility clinical record. The resident was documented as having been lying in bed with immobilizers on the left upper and lower extremities at the time of the evaluation. Unmanaged pain and weakness were noted. [DIAGNOSES REDACTED]. The visit summary/care plan addressed pain with medication, constipation with medication and it noted multiple fractures with follow up by the hospital physician scheduled for 8/10/20. Therapy was to be continued and the nursing staff were monitor the resident's temperature daily, and notify the physician about any abnormal lab work or sudden changes in condition. There was no documentation indicating that the hospital history and physical (H&P) and discharge summary, indicating an ongoing need for [MEDICATION NAME], were reviewed by the attending physician. There was no mention of anticoagulant use. A review of the visit note for 8/3/20, revealed the visit was conducted via telehealth. The resident was noted in bed during the evaluation with immobilizers in place on the left upper and lower extremities. The progress note indicated findings of a physical exam performed including: eyes, pupils equal, round reactive to light, respirations abnormal decreased sounds at bases, soft, nontender abdomen without masses and active bowel signs. The resident complained of left lower leg pain, and a Doppler study was ordered to rule out [MEDICAL CONDITIONS]. [DIAGNOSES REDACTED]. The visit summary/care plan addressed pain with medication, constipation with medication and it noted multiple fractures with follow up by the hospital physician scheduled for 8/10/20. Therapy was to be continued and the nursing staff were monitor the resident's temperature daily, and notify the physician about any abnormal lab work or sudden changes in condition. There was no documentation indicating that the hospital history and physical (H&P) and discharge summary, indicating an ongoing need for [MEDICATION NAME], were reviewed by the attending physician. There was no mention of anticoagulant use. According to RxList at https://www.rxlist.com/[MEDICATION NAME]-side-effects-drug-center.html: [MEDICATION NAME] ([MEDICATION NAME] sodium) Injection is an anticoagulant (blood thinner) used to prevent blood clots that are sometimes called [MEDICAL CONDITIONS], which can lead to blood clots in the lungs. A [MEDICAL CONDITION] can occur after certain types of surgery, or in people who are bed-ridden due to a prolonged illness. Obese patients are at higher risk for [MEDICAL CONDITION]. According to Healthline at https://www.healthline.com/health/[MEDICATION NAME]-injectable-solution: [MEDICATION NAME] is used to thin your blood. It keeps your blood from forming clots. Blood clots are dangerous because they can lead to serious blockages in your blood vessels. This can cause a stroke or a [MEDICAL CONDITION]. This drug is used to prevent blood clots in people who are hospitalized . It may be used if you 're too sick to move around. It ' s also used to prevent blood clots at home after you ' ve had stomach surgery or a hip or knee replacement. This drug is also used to treat existing blood clots in the hospital or at home. If you stop taking the drug suddenly or don ' t take it at all: You ' ll have a higher risk for a blood clot. This could lead to serious problems, such as a stroke or death. Take this drug on the schedule set by your doctor. Don ' t stop taking it without speaking with your doctor first. .
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 a review of resident and facility records and interviews with staff, the facility failed to maintain complete and accurate clinical records for two (Residents #2 and #1) of three residents whose records were reviewed. The findings include: 1. A closed record review for Resident #2 found she was admitted to the facility on [DATE] from an acute care hospital. She was [AGE] years old. A review of hospital records found Resident #2 was seen in the emergency roiagnom on [DATE] prior to her admission to the facility. The attending physician's [DIAGNOSES REDACTED]. Resident #2 had [DIAGNOSES REDACTED]. A review of the clinical record revealed Resident #2 had a 6-page Admission Data Assessment Form dated 7/28/20, noting her new admission to the facility. Despite her multiple [DIAGNOSES REDACTED]. It only noted that Resident #2 was alert and oriented to her person, had no drug allergies and no past events that would affect her behavior. The medications [MEDICATION NAME] (blood thinner), [MEDICATION NAME] (antipsychotic) and [MEDICATION NAME] (antipsychotic) were listed. The remaining sections intended to assess the following conditons were not completed: Immunization dates, vital signs, language spoken, weight, height, memory status, hearing, modes of expression, mood, behaviors, oral status, cardiovascular status, respiratory status, vascular access, assistive devices, neurological status, gastrointestinal status, [MEDICAL CONDITION] status, pain and skin condition. In addition, the safety, elopement risk, fall risk, and other evaluations were left blank. The section asking if the resident was oriented to the facility was blank, and there were no admission nursing notes. Finally, there were no nurses' signatures. A review of the nursing progress notes for this resident found there was no comprehensive admission note and no admission evaluation. Resident #2 had a physician's orders [REDACTED]. The physician's progress note dated 7/29/20, also referenced Resident #2's [MEDICATION NAME] for [MEDICAL CONDITION]. A review of the july 2020 medication administration record (MAR), revealed the signature box for Resident 2's [MEDICATION NAME] was initialed on 7/29/20, but the initials were circled indicating the medication was held or not given. The back of the MAR had no explanation as to why the medication was not given. On 7/30/20, [MEDICATION NAME] appeared to have been signed out twice, and on 7/31/20 it was left blank with no explanation why. An interview was conducted with the Regional Nurse Consultant at 3:15 pm on 8/17/20. She stated the expectation for new admissions was for the admitting nurse to complete the admission assessment within two to four hours of admission. She reviewed Resident #2's admission assessment, confirming the form was not only blank but that the admitting nurse did not sign it. She confirmed no comprehensive admission assessment was completed on admission for this resident. An interview was conducted with the Director of Nursing (DON) at 5:50 pm on 8/17/20. She reviewed Resident #2's MAR and confirmed that the circled initials on 7/29/20 indicated either an omission or that the medication was not available. She stated her expectation was for a note to be authored on the back of the MAR to explain the reason for the omission. The DON confirmed the [MEDICATION NAME] was not signed for on the 31st, but she did not know why. The facility Policy and Procedure on Admission Assessment, policy N-100 (revised 8/22/17) noted that at the time of admission the nurse shall initiate the data collection form. Pertinent information shall be collected by physical review, interview with residents and family and review of the available medical records. The Data Collection form will be completed within 24 hours of admission. 2. A review of Resident #1's clinical record revealed a [AGE] year-old female admitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident #1's hospital record, provided to the facility by the hospital upon the resident's nursing home admission, revealed the following: On 7/27/20, Resident #1 was seen by the trauma Advanced Practice Registered Nurse (APRN) for discharge orders. The orders included: Follow up with the orthopedic surgeon in one week for suture removal, PT and OT daily, non-weight bearing x 4 weeks, pain control, regular diet, maintain dressings clean and dry to all sites, and [MEDICATION NAME] 40 mg twice daily to prevent [MEDICAL CONDITION] ([MEDICAL CONDITION] - blood clot). Also, on 7/27/20 the hospitalist working with the APRN documented that he reviewed the resident's history, personally evaluated the resident and agreed with the APRN's assessment and plan. The addendum included [MEDICATION NAME]. A review of the surgeon's note dated 7/27/20, included the following instructions: Pain control, regular diet, non-weight bearing right and left leg, five pound weight bearing for left upper arm, elevate left upper arm and right lower leg, PT and OT, [MEDICAL CONDITION] (prevention) and [MEDICATION NAME] 40 mg twice daily. A review of the Admission Data Collection form dated 7/28/20, revealed there was no time of data collection recorded, it did not include vital signs, surgical dressings in place, multiple fractures, knee immobilizer in place or a pain assessment. There were no initial nursing notes or a physical assessment. A review of the nursing notes for 7/29/20 and 7/30/20 lacked any physical assessments including surgical sites, circulation or physical changes of the extremities due to multiple fractures. Further review of the record found no nursing notes or assessments for 7/31/20 or 8/1/20. The nursing documentation for 8/2/20 found no physical assessments recorded. The nursing note dated 8/3/20 on the 11PM to 7AM shift, revealed no documentation of a change in condition related to the resident's left leg. There were no nursing notes completed or assessments performed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105653	A. BUILDING _____ B. WING _____	**08/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CONSULATE HEALTH CARE OF ORANGE PARK	**1215 KINGSLEY AVE ORANGE PARK, FL 32073**

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F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 4) for the 7AM to 3PM or 3PM to 11PM shifts on 8/3/20 related to the change of condition warranting a Doppler study of the left leg. A physician's orders [REDACTED]. Results of the Doppler study revealed an occlusive venous [MEDICAL CONDITION] (blood clot) of the left leg. There was no nursing note or physical assessment for 8/4/20. A review of the transfer sheet for transport to the hospital, dated 8/4/20 at 4:56PM gave no reason for the transfer or notification of Resident #1's family. Resident #1 was admitted to the hospital on [DATE] and underwent surgery to remove the blood clot in her left leg. During an interview with the interim Director of Nursing (DON) on 8/17/20 at 1:30PM, she was asked if there were nursing notes for Resident #1 on 7/31/20, 8/1/20, 8/3/20 or 8/4/20. She stated she would check with the Medical Records Department. When she returned, she said she was told everything the resident had on file was in the record. She was asked whether the nurses documented every shift on residents who were receiving skilled services. She said, Usually once a day and more if there were changes or new orders. She was asked if there were daily skilled nursing (SN) notes for Resident #1. After a review of the notes, she stated the record was incomplete and no skilled nursing notes had been recorded for several days. She was asked if any of the notes in the chart reflected a change in condition or a need to transfer Resident #1 to the hospital and she replied no. The DON was also asked if the medication reconciliation form (MRF) was to be signed by the physician, and she replied no, it was a tool for the nurses. She was asked to review the MRF for Resident #1, dated 7/28/20. When asked if the nurse checked off that she had reviewed the hospital records, the DON said yes. She was asked whether the nurse documented any reference from the hospital physicians for the continued need for [MEDICATION NAME]. She said not that she could find. An interview was conducted with the attending physician for Resident #1 on 8/17/20 at 1:40 pm. He was asked if he had treated Resident #1 when she was at the facility. He said yes, she had been in a motor vehicle accident (MVA) with multiple fractures. When asked why she had been transferred to the hospital on [DATE] he stated she had developed a blood clot in her leg. He was asked if he had ordered anticoagulant (blood thinner) medication upon admission, and he stated he ordered Eliquis after a Doppler study revealed a blood clot in her leg. When asked whether she had received the Eliquis, he stated he did not know but said she did go to the hospital the day after the Doppler. He was asked whether he was aware that Resident #1 was taking [MEDICATION NAME] during her hospital stay and that two physicians and an APRN documented on 7/27/20 (the day before admission to the facility) that she needed to continue the [MEDICATION NAME]. He said he did not recall if he saw her or his partner saw her, but it would be in the progress notes. He was asked if he had reviewed the hospital discharge records, and he stated he would need to refer to the progress notes. When asked where he documented his progress notes, he stated they were dictated and brought to the facility to be filed in the record. He was informed that there were no physician's progress notes in the the resident's clinical record (20 days after the resident's admission). He stated he would contact his office and have the notes sent to the facility via e-mail so they would be available. He further stated that in his notes, or if it was his partner that saw her, in their notes, there would be a reference to the hospital records and any need for an anticoagulant. During an interview with the Administrator on 8/17/20 at 2:15 pm, she was asked if she had received the physician's progress notes for Resident #1. She said she had not yet received them, but would provide them as soon as the email arrived. She was asked again at 3:30 pm and 4:30 pm, and said she would call the physician's office to find out where they were. At the time of the exit conference (6:15 pm), the progress notes had not been provided. The Administrator emailed the physician's progress notes to the field office on 8/21/20 at 4:30 pm (four days after the survey exit). .