STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105365	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LIFE CARE CENTER OF ALTAMONTE SPRINGS	989 ORIENTA AVE ALTAMONTE SPRINGS, FL 32701

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** Based on observation, interview and review of the room checklist, the facility failed to ensure that the wall behind the resident's bed and headboard were maintained in good condition for 1 of 212 residents residing in the facility. Findings: On 3/02/20 at 12:47 PM , the wall behind the head of the bed for resident #135 was severely damaged. The headboard had a thick layer of drywall dust on the top of the frame. The headboard was missing the trim on the right side when looking towards the head of the bed. On 3/04/20 at 4:34 PM, the wall and headboard remained in the same condition as observed on 3/02/20. The maintenance director said he was not aware of the damaged wall, and that the damage did not appear to be new. He said the certified nursing assistants were supposed to report damage in the electronic work (TELS) order. It was not entered in the TELS system, so he was not aware of the damage. The Quality Assurance-Resident Room Check List for housekeeping \read, Walls are free from dust and mildew, hair, spider webs, and grit. All furniture is free from dust (includes bed frames). At the bottom of the checklist there was a line NOTE: Any maintenance Department related issues should be reported via completion of a work order.
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 observation, interview and record review, the facility failed to accurately assess behavior for wandering for 1 of 9 residents reviewed for accident (#179) and failed to ensure an accurate quarterly assessment was completed for [MEDICAL TREATMENT] for 1 of 1 resident reviewed for [MEDICAL TREATMENT] (#70) out of 72 total sampled residents. Finding: 1. Resident #179 was admitted to the facility on [DATE], her [DIAGNOSES REDACTED]. The quarterly minimum data set (MDS) assessment, with assessment reference date (ARD)11/11/19, and the annual MDS with ARD 2/09/20, showed that resident #179 was unable to complete the brief interview of mental status. The section E0900 Wandering-Presence & Frequency question Has the resident wandered was coded 0 indicating that the behavior was not exhibited. The following section E1000 Wandering-Impact was not answered. The resident's Quarterly assessment dated [DATE] read, Resident is an elopement risk, she remains on A-Wing secured side. Resident is visible to the community as she walks up and down the hallways daily. Progress note dated 2/06/20 read,Resident is alert with confusion Continues to wander the halls which is resident's norm. Observations on 03/02/20 at 10:55 AM, 11:40 AM, 2:28 PM, 4:51 PM, 4:53 PM, on 3/04/20 at 9:35 AM, 11:04 AM, and at 4:49 PM, showed resident # 179 self-ambulating, in the dining/activities room, on the secured unit, in the hallway, and entering other residents' rooms. On 03/02/20 at 5:06 PM Licensed practical nurse (LPN) H stated that resident #179 was a wanderer. LPN H stated, that for the most part, the resident would go into other residents' rooms, and would come right back out, very rarely would the resident pick up something from the rooms. On 03/04/20 at 9:35 AM resident # 179 was ambulating in the hallway on the secured unit. The resident was trying to push the mechanical lift, and the treatment cart. On 03/04/20 at 9:39 AM Certified nursing assistant (CNA) K stated that she has been working at the facility for six years and worked on the secured unit on the 7AM-3PM shift. CNA K stated that resident # 179 ambulated throughout the day, and staff had to watch her frequently. On 03/04/20 at 11:03 AM LPN I stated, that resident #179 ambulated frequently, and had to be redirected continually. LPN I stated that the physician, and all staff members were aware of the resident's frequent ambulation. LPN I stated that the resident also goes into other residents' rooms. On 03/04/20 at 4:49 PM resident # 179 was ambulating in the hallway, and into another resident room. The resident was walking around in the room, smoothing the bed linen, and was then sitting in a chair in the room behind the partially closed door. At 4:55 PM the resident was again ambulating in the hallway and was observed close to the exit doors of the secured unit. On 03/05/20 at 9:31 AM LPN H stated, that resident#179 was admitted to the secured unit since her admission to the facility. LPN H stated that she had been taking care of the resident for about three years, and the resident has been exhibiting behaviors of wandering, since she has been taking care of her. On 03/05/20 at 10:06 AM Social Services Assistant (SSA) J stated that she completed Sections C, D, E of the resident's quarterly, and annual minimum data set assessments. SSA J stated that the resident's behaviors of ambulating in the hallway, and into other resident's rooms were considered wandering. The resident's minimum data set assessments were reviewed with SSA J. She stated that the question Has the resident wandered was coded as 0 indicating that the behavior of wandering was not exhibited. SSA J said, that if she had coded the question with a 1, 2 or 3, the follow up questions, at section E1000, Wandering-Impact would have to be answered and the resident was not going on the stairs, or outside the facility. SSA J stated, that the following question, Does the wandering significantly intrude on the privacy or activities of others? would apply to the resident, since the resident does intrude on the privacy of others. SSA J stated, that she read the questions wrong, and the question Has the resident wandered should have been coded as 3, indicating that the behavior occurred daily. She stated that, in section E1000, the question Does the wandering significantly intrude on the privacy or activities of others? should have been answered with a yes. This was confirmed by the Social Services Director (SSD). SSA J stated that a modification of the assessment would be completed. Due to the inaccurate assessment, a care plan for the resident's behavior of wandering was not developed. On 03/05/20 at11:06 AM the director of nursing (DON) stated, that resident # 179 had exhibited behaviors of wandering since she has known the resident. The DON stated that the resident was admitted to the secure unit, and her behavior was considered wandering. In a review of the resident's clinical records with the DON, a person-centered care plan for the resident's behavior of wandering could not be identified. This was confirmed by the DON. The DON stated that care plans were developed by the Interdisciplinary Team (IDT) using the MDS assessment. 2. Resident # 70 was initially admitted on [DATE], readmitted on [DATE]. His [DIAGNOSES REDACTED]. He went to [MEDICAL TREATMENT] at an outside facility every Mondays, Wednesdays and Fridays. Record review of information obtained from [MEDICAL TREATMENT] center revealed that resident #70 started [MEDICAL TREATMENT] on 01/13/2018. The annual minimum data set ((MDS) dated [DATE] indicated that resident was cognitive. He required extensive assistance of 1 person for bed mobility, dressing and toilet use. He was able to eat his meals as long as staff set it up for him. He required an indwelling catheter to prevent retention of urine. The MDS revealed that resident #70 was on [MEDICAL TREATMENT]. Record review of latest quarterly assessment of MDS dated [DATE] indicated that resident was not on [MEDICAL TREATMENT]. On 03/04/2020 at 3:18 PM, MDS director stated that according to the records that she was looking, the resident had been on [MEDICAL TREATMENT] since April of 2019. She also stated that there was a discrepancy on the assessment submitted on [DATE]. The facility's policy, Resident Assessment Instrument & Care Plan last reviewed on 4/29/19 read, The information identified using the MDS and Care Area Assessment process is used to develop an individualized person-centered Care Plan.
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**

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 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) **goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to identify non-pressure related skin condition for 1 of 1 resident reviewed for skin condition non-pressure related (#190) from a sample of 72 residents. Finding: Resident #190 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The resident's quarterly minimum data set (MDS) assessment, with assessment reference date 2/19/2020 revealed that the resident's cognition was severely impaired, with a brief interview of mental status (BIMS) score of 4/15. Resident #190 required extensive assistance for bed mobility, transfer, dressing, eating, toilet use, and personal hygiene. The resident's current physician's orders [REDACTED].) every 12 hours. [MED] ([MED]) is used to prevent serious blood clots from forming. (WebMD) A review of the resident's Weekly Skin integrity Data Collection evaluations for the following dates:1/06/20, 1/13/20, 1/20/20, 1/27/20, 2/03/20, 2/10/20, 2/17/20, 2/25/20, and 3/03/20 revealed the resident's skin was intact, and there were no new findings. On 3/03/20 at 10:38 AM, resident #190 sat in her wheelchair in the dining/activities room on the Secured unit. The resident's right forearm had areas of discoloration, bruises, and scab, and a band aid was on the resident's right shin. On 3/04/20 at 11:24 AM, licensed practical nurse (LPN) L stated that the resident's skin was checked weekly by the nurse. LPN L stated that resident #190 was on the medication [MED], and was prone to bruises. She stated that if the residents have any new skin issues, an incident report is initiated, and the physician is informed On 3/04/20 at 4:29 PM, LPN L stated that she completed a head-to-toe inspection of resident #190, and did not see any discoloration and/or scabbing on the resident's right arm. An observation of the resident's right arm was conducted with LPN L. The LPN confirmed that the resident's right arm had areas of discoloration, bruises, and scabbing. A small area of discoloration was also noted to the resident's right shin. LPN L could not say when the discoloration, bruises, scabbing was identified, and documentation to address the findings could not be identified by LPN J. On 3/04/20 at 4:32 PM, the Assistant Director of Nursing (ADON)/Risk Manager (RM), present during the observation with LPN J, stated that skin observation was conducted by the staff, and if there were any new issues, the observation should be documented. If the residents have a skin tear, the facility's incident report should be initiated. Review of the resident's clinical records did not reveal any documentation regarding the discolorations, bruises, and scabs to the resident's right arm, or discoloration to the resident's right shin. This was confirmed by LPN L. On 3/05/20 at 11:02 AM, the DON stated that every resident in the facility was on a weekly skin check, and any new finding ought to be addressed, reported in the facility's Risk portal, with documented notification of the physician, and family, treatment order in place, and the findings care planned. On 3/05/20 at 2:45 PM, the DON stated that the resident's skin had been addressed. When asked when it was addressed, the DON said on 3/05/20 at 11:02 AM. The DON confirmed that documentation to address the resident's skin could not be identified. She reported that the resident was seen and assessed by the ADON/RM, and her skin issues were documented on, and an incident report was initiated on 3/05/20, during the survey. On 3/05/20 at 3:19 PM, the ADON/RM stated that she observed a skin tear to the resident's left lower arm, dry scab, and bruises in various stages of healing to her right arm. The ADON/RM stated that the resident did a lot of packing and unpacking, and bruises, and skin tear could have happened when she was reaching in and out of her boxes. The ADON/RM stated that for any new skin issues, staff were to complete a progress note, complete a skin assessment at the time the skin issue was identified, and complete an incident report on the facility's risk management portal. The ADON/RM stated that she checks the risk portal daily to follow up on any incident, to investigate, and to ensure interventions are in place. The ADON/RM stated that an incident report was completed on 3/05/20, during the survey. She stated that the discoloration, bruises, scabbing to the resident's skin should have been identified and the various steps followed. The ADON/RM stated, that the facility could not say when the resident's injuries/skin tears occurred, documentation regarding the observations could not be identified until 3/04/20 after the surveyor's interview and observation with LPN L. A care plan for Risk for impaired skin integrity -Resident is at risk for impaired skin integrity related to impaired mobility, impaired cognition .Use of Anti-Coagulant medication which puts resident at risk for bruising .Use of meds that can cause drowsiness (increased risk of injury to skin) was created on 5/29/19, and last reviewed on 2/26/2020. Interventions included, Observe skin integrity during care, report any new areas of abnormalities to nurse and MD (medical doctor) including but not limited to (skin tears, cuts, lacerations, rashes, redness, bruises) The facility's policy, Event Management System Policy, with effective date 5/23/19 read, The Event Management policy is designed to assist the facility in identifying and reducing events. Event Management includes, but is not limited to, the following types of events .Injury of unknown origin .skin integrity injury, bruise, burn, skin tear .At the time of the event .The licensed nurse will document an event note, update the care plan .The licensed nurse will initiate the incident report in the electronic system and assign an event type and risk level .The nurse initiating the event report will notify his/her immediate supervisor of the event at the time of the event and not later than shift change .The nurse will notify the resident's physician and legal representative at the time of the event.
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure oxygen (O2) concentrators were cleaned and filters maintained for 2 of 3 residents reviewed with oxygen therapy (#186 &150). Findings: 1. Resident #186 was a resident since 11/21/17. Her [DIAGNOSES REDACTED]. Her quarterly minimum data set assessment, dated 2/14/20, signed as complete on 2/18/20, noted that she was receiving oxygen therapy. She had a plan of care dated 2/18/20 for respiratory risk with interventions including apply oxygen as indicated, change oxygn tubing and humidifier as indicated, check oxygen sat and breathe sounds as needed. On 3/02/20 at 12:40 PM, resident #186 was in her bed sleeping. She received oxygen via nasal cannula. The concentrator was supplying 3.5 liters/minute (l/min) of O2. The resident had no visible signs of distress. The O2 concentrator was at the side of the bed closest to the window. There was a layer of white dust visible under the O2 level control. On 3/03/20 at 12:53 PM, the resident was again in bed with the concentrator supplying O2 at 3.5 L/min. The dust remained under the O2 level control. On 3/04/20 at 4:34 PM, the concentrator remained soiled with dust. The maintenance director confirmed it was soiled. He stated that housekeeping or central supply staff were responsible for cleaning the concentrator. On 3/04/20 at 5:33 PM, the central supply person said that housekeeping was responsible for wiping the concentrators down. On 3/05/2020 at 11:17 AM, the Director of Nursing stated that Central Supply was responsible for the wiping down the concentrators. On 3/05/2020 at 2:40 PM, the housekeeping director stated that housekeeping services are responsible for cleaning of the O2 concentrators. 2. Resident #150 was initially admitted on [DATE] with [DIAGNOSES REDACTED]. On 3/03/2020 at 5:01 PM, resident #150 was in bed. The O2 concentrator was set at 2 liters per minute (l/pm). The rear filter was clogged with dirt. The resident's O2 plastic tubing was not labeled. A plastic bag dated 3/02/2020 with new plastic tubing inside was on top of the O2 concentrator. On 3/04/2020 at 11:05 AM, resident #150 was in bed. The O2 concentrator was set at 2 l/pm. The rear filter was clogged with dirt. On 3/04/2020 at 5:55 PM, resident #150 was in bed. The O2 concentrator rear concentrator filter was still clogged with dirt. On 3/04/2020 at 5:35 PM, the Central Supply Director (CSD) stated the nurses on the 11 PM to 7 AM shift on Thursdays are responsible of replacing the O2 concentrator unit tubing, and housekeeping are to clean and wipe (down the concentrators out the O2 units. She did not know who was responsible for cleaning the O2 concentrator filters. On 3/05/2020 at 10:43 AM, Unit Manager (UM) D stated that housekeeping was in charge of cleaning the concentrators housing and the rear filters as necessary. On 3/05/2020 at 11:17 AM, the Director of Nursing (DON) stated that Central Supply was responsible for the rear concentrator filters; she stated that they have a contract with a company who provides preventive maintenance and calibration services to the O2 concentrators. On 3/05/2020 at 2:40 PM, the Housekeeping Director stated that housekeeping services are responsible for cleaning of the O2 concentrators including the removal for cleaning and replacement of rear filters. Review of the care plan completed on 3/02/2020 noted Respiratory risk, Potential for Acute Respiratory Distress, Resident has PRN (as needed) oxygen therapy order - Administer respiratory medication as per order, apply oxygen as indicated, change oxygen tubing and humidifier as indicated, check oxygen sat and breathe sounds as needed. A review of the facility's Policy for Respiratory Services (Clinical Services Manual). Oxygen Administration/ Safety/Storage/Maintenance - Effective Date: 12/03/2018 and Reviewed on 4/15/2019 noted; Infection Control: Section 1 noted Change oxygen supplies weekly and when visibly soiled. Equipment should be labeled with patient name and dated when setup or changed out. Section 4 noted Clean exterior of concentrators weekly with bactericidal surface cleaner. External filter

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F 0695 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) should be checked daily and all dust should be removed. Filters should be washed with soup and water once each week and PRN. Dry with a towel and reinsert. Discard and replace when damaged. Review of the facility Quality Assurance - Check List for Housekeeping noted Equipment such as TVs, Concentrators, IV Poles, etc. are clean.
F 0758 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the use of as needed (PRN) [MEDICAL CONDITION] medication use was limited to 14 days for 2 of 5 residents reviewed for Unnecessary Medication, [MEDICAL CONDITION] Medication, and Medication Regimen Review (#144 & 174). Findings: 1. Resident #144 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Physician orders [REDACTED].) 1 tab every 8 hours as needed ordered 1/27/2020. The care plan dated 2/06/2020 read, At risk for adverse side effects from [MEDICAL CONDITION] Medication relating to prn anti-anxiety medication due to [DIAGNOSES REDACTED]. She also stated resident did not receive [MEDICATION NAME], so it should be discontinued. 2. Resident #174 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The resident's current physician orders [REDACTED]./ml.) vial give 0.25 ml. every 8 hours as needed for [MEDICAL CONDITION] related to unspecified dementia with behavioral disturbance. Hold for increased lethargy may give IM (intramuscular) if unable to take by mouth. A Pharmacy recommendation dated 12/03/19 read, has PRN order for anxiolytic, which has been in place for greater than 14 days without a stop date. Recommendation was, please discontinue PRN [MEDICATION NAME]. The facility's physician declined the recommendation, and documented, Cont (continue) PRN reevaluate in 1 month. the response was dated 1/06/20. On 3/04/20 at 11:28 AM, the resident's physician orders [REDACTED]. The LPN confirmed that the resident's current physician orders [REDACTED]. LPN L stated that the facility's physician wanted the PRN [MEDICATION NAME]. On 3/04/20 at 11:39 AM, the facility's physician stated that resident #174 was on scheduled and PRN [MEDICATION NAME]. The facility's physcian stated that PRN [MEDICATION NAME] was last administered on 8/18/19, and was still on the current POS. The physician stated that if the residents did not take the medications for sixty days, the medications should be discontinued. The physician said he could not speak to why the PRN [MEDICATION NAME] order was still active. He stated he could tell why the medication was initiated, but not why it was not discontinued. 3/04/20 at 11:42 AM, the Assistant Director of Nursing/Risk Manager (ADON/RM) stated, that the facility generally tries to keep anti-anxiety PRN medications for 14 days unless warranted by the physician for continued use. The ADON/RM stated, that even if the PRN [MEDICAL CONDITION] medication was warranted by the physician, the medication should be renewed every fourteen (14) days. She stated that the facility did not have a policy to address the renewal of PRN [MEDICAL CONDITION] medications. The facility followed the Center for Medicare & Medicaid Services, and the Federal and State regulatory guidelines. On 3/04/20 at 12:32 PM, the facility's physician stated that in reviewing the resident's medications, she was on the PRN, in case she was unable to take medication by mouth. The pharmacy recommendation's physician response, and the regulatory guidance was discussed with the physician. PRN orders for [MEDICAL CONDITION] drugs are limited to 14 days if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. The physician stated that he understood. On 3/05/20 at 10:42 AM, the DON stated that the facility did not have a policy that speaks to the renewal of PRN [MEDICAL CONDITION] medications, the facility followed the State and Federal regulation. She confirmed that the resident's PRN [MEDICATION NAME] should have been renewed every fourteen days if the medication was to be continued.