STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105520	A. BUILDING _____ B. WING _____	**07/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CONSULATE HEALTH CARE OF BRANDON	**701 VICTORIA ST BRANDON, FL 33510**

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F 0686 **Level of harm -** 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 record review, observations, interviews, and policy review the facility did not ensure residents received the necessary care for pressure ulcers to promote healing and prevent infection in regards to a resident who was noted to have an open area on the sacrum/coccyx area and who did not receive treatment for 10 days after the wound was noticed, and the facility failed to ensure residents received wound care as ordered and according to professional standards to prevent infection for two (#1, #8) of two residents reviewed of 7 total residents with pressure ulcers in the facility. Findings included: 1) Resident #1 was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. A review of the MDS (Minimum Data Set) assessment dated [DATE] showed that Resident #1 had a BIMS (Brief Interview for Mental Status) score of 10, . Section G, functional status, showed Resident #1 needed extensive assistance of two persons for bed mobility and transfers. Resident #1 required extensive assistance of one person for personal hygiene, dressing, eating, and toileting. She was totally dependent on one person for bathing assistance. Resident #1 had bilateral lower extremity impairment. Review of Section M, skin conditions, reflected a stage three pressure ulcer that was present on admission. A pressure reducing device for the bed was marked yes. Pressure ulcer care was marked yes. Application of nonsurgical dressings was marked yes, and application of ointments/medications was marked yes. A review of the nurse's note dated 6/15/20 revealed that during the evening shift an opened area was noted to the resident's sacrum/coccyx. The site was noted with moderate amount of drainage and tissue loss/damage. Area cleaned and dressing applied to site, facility's DON (director of nursing) made aware, order initiated for a wound care consult reevaluation and tx (treatment) as indicated. Staff assist with turning/repositioning on going to off load pressure areas, nurse monitoring continues. On 7/7/20 at 4:10 p.m. an interview was conducted with Staff G, RN agency staff. She said when she was caring for Resident #1 on 6/15/2020 the CNA (certified nursing assistant) came out and told her the resident needed a dressing to her buttocks. Staff G, RN said when she looked at the orders in the medical record there wasn't a dressing ordered. Staff G, RN said she went in the room and when they tuned the resident over there was a foul odor. Her buttocks were necrotic (tissue death), the skin was peeling away. Review of a progress note dated 5/14/2020 signed by a nurse showed, Resident #1, seen by (wound care physician), sacral wound resolved, left labia quality of wound improved will continue treatment, scratch noted right forearm, no s/s(signs and symptoms) of drainage noted to site, new orders obtained and transcribed, will continue to monitor and treat. A review of the 5/22/20 Weekly Skin Integrity Review showed the following: Skin Intact No Current Skin Condition, Gluteal area (redness), L (left) labial (blister), R(right) F(fore) arm (scratch), Notes: treatment in place, signed by a nurse. A review of the 5/29/20 Weekly Skin Integrity Review showed the following: Skin Intact No, Current Skin Condition, Gluteal area redness, L labial Blister, Notes: treatment in place, signed by a nurse. A review of the 6/5/20 Weekly Skin Integrity Review showed the following: Skin Intact No, Current Skin Condition: L Labial blister, gluteal area redness, Coccyx, open pressure sore No other information was documented. Signed by a nurse, Staff M. A review of the 6/12/20 Weekly Skin Integrity Review showed the following: Skin Intact No, Current Skin Condition: Sacrum pressure area, gluteal area redness, left labia blister No other information was documented. Signed by a nurse, Staff M. A review of physician's orders [REDACTED]. A review of the physician's orders [REDACTED]. Pat dry. Apply skin prep to periwound. Apply [MEDICATION NAME] with collagen to wound and cover with dry dressing every shift and prn (as needed). There wasn't a treatment ordered in June prior to 6/15/20. A review of the treatment administration record (TAR) for June 2020 showed an order dated 6/15/20 cleanse entire site to buttocks with normal saline pat dry apply skin prep to periwound apply [MEDICATION NAME] with collagen to wound and cover with dry dressing every shift and prn. Treatments were signed on the 15th, 16th, and 17th. Further review of the June TAR showed no treatments were ordered prior to 6/15/20, indicating there wasn't a treatment for [REDACTED]. Further review of the medical record for the month of June 2020 revealed no measurements or assessments were completed for the pressure ulcer. On 7/8/20 at 10:54 a.m. an interview was conducted with the DON (director of nursing). She said she doesn't know if any assessments were completed on that wound. On 7/8/20 at 11:05 a.m. a follow up interview was conducted with the DON. She said she couldn't find any measurements or assessments for Resident #1's pressure ulcer. On 7/8/20 at 11:30 an additional interview was conducted with the DON. She said the wound care nurse was seeing the residents every week for their assessments. The wound care nurse went out on 5/14/20 sick and has not been back since. She said she is the only other administrative RN who would sign off on or complete wound assessments. She said she did see Resident #1's wound. It was unstageable. At 3:30 p.m. on 7/8/20 a follow up interview was conducted with the DON. She said she saw there were issues with the treatment orders; no measurements or assessments were being done. Treatment orders and treatments weren't being done. On 7/13/20 at 3:32 p.m. in an interview with the DON she said she wasn't made aware there wasn't a treatment for [REDACTED]. The DON said she does wound rounds on the residents that the wound care physician sees. Resident #1 wasn't on her list. The DON said she couldn't recall if Resident #1 had an air mattress. She said she saw where the wound was open on the 14th, but she didn't see anything before that. On 7/13/20 at 3:57 p.m. in a follow up interview with the DON she confirmed there was not a treatment in place for the gluteal redness or the open area on the coccyx until 6/15/2020. She said the nurse is expected to call the physician and get an order in place. On 7/13/20 at 4:15 p.m. a telephone interview was conducted with Staff M, LPN agency. She said she doesn't remember the date, but she does remember the open area. The physician was there and was aware. He already knew about it, and he said he had requested for her to be seen by the wound care physician. It was not a new wound. No, there was not a treatment for [REDACTED]. I can't speak to what his decision was, but I made him aware. That is my responsibility. She said she doesn't work at the facility very often, and doesn't know if there is a protocol in place for treatments. There is a wound care doctor who comes in and sees them and writes orders for treatment. He is there very regularly. On 7/13/20 at 4:22 p.m. another interview was conducted with the DON. She said somebody documented in the note that they notified the DON, but they did not. They should have notified the physician and the family as well as herself. If she had been aware of it, she would have notified the doctor immediately and gotten a treatment in place for it. The Medical Director was interviewed because the primary physician was unable to be reached. At 4:33 p.m. on 7/13/2020 The Medical Director said there is a wound care specialist in the facility and a wound care nurse who takes care of the wounds. They have a nurse covering for her because she went out sick with COVID. She said That is odd when told of the lack of treatment for 10 days for Resident #1. She said the wound care doctor comes once a week and the wound care nurse takes care of them. No she was not aware that there was any problem. She said, I have the note from the wound care physician. Not all the doctors write a note in the chart. Yes, the last note from the wound care doctor was on 5/14. When the wound care nurse isn't working they still have a wound care doctor and a nurse who sees them. They changed wound care companies about 6 months ago. The wound care physician is there every week. Later that day the Medical Director said that the nurses were doing their own wound care while the wound care nurse is out sick. They do the treatments every day. She referred this surveyor to the Resident's physician for more information. Review of the policy, Notification of Change in Condition, dated 9/21/17 revealed the following: Policy The center to promptly notify the patient/resident, the attending physician, and the resident representative when there is a change in the status or

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

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F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) condition. Procedure: The nurse to notify the attending physician and resident representative when there is a (an): (bullet 4) New treatment 2) Resident #8 was readmitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. A review of the physician's orders [REDACTED]. A review of the MAR (medication administration record) for July 2020 showed treatments were not provided from 7/4/20-7/5/20 At 4:00 p.m. on 7/8/20 an observation was conducted with Staff K, RN during a dressing change for Resident #8. Staff K, RN prepared the supplies for the treatment including an adhesive dressing, rolled gauze, wound cleanser, hypochlorite solution, and two pairs of unbagged scissors he removed from the treatment cart. Staff K, RN put on personal protective equipment (PPE) as indicated by signs on the door indicating droplet precautions. After entering the room, Staff K, RN set the dressing change supplies on the bedside table except for the scissors, which he placed on paper towels. He did not clean the bedside table or put a barrier on it for the other supplies. The nurse removed a felt tipped pen from his uniform and opened and dated the dressing. He removed the gloves, and washed his hands in the sink. He put on a clean pair of gloves. Then he went to the door and asked a CNA to come assist. Staff L, CNA also put on the PPE before entering the room. She washed her hands in the sink and put on a pair of gloves. Resident #8 was lying on his right side with the head of the bed elevated to about 45 degrees. He was covered with blankets. After lowering the head of the bed and raising the bed height, Staff L, CNA removed the blankets and took the pillows out from between Resident #8's knees. Resident #8 was contracted at the elbows, wrists and knees. The mattress was a regular mattress and not a pressure relieving air mattress. Staff L, CNA removed the adhesive tab from his brief and assisted Resident #8 to his right side, toward her. The dressing on his sacral area was dated 7/8/20. The nurse removed the dressing and placed it in the trash can. Then he removed his gloves and washed his hands in the sink. He put on a clean pair of gloves and cut some of the rolled gauze with a pair of scissors. He sprayed the gauze with the wound cleanser. He cleaned the inside of the wound on Resident #8's coccyx. Then he cleaned all around the wound with the same gauze. He put the used gauze in the trash can and removed his gloves and washed his hands in the sink. He put on a new pair and cut some gauze which he used to pat the wound dry, and then the surrounding area. He removed his gloves and washed in the sink. He put on new gloves and saturated some more gauze he had cut with the hypochlorite solution. He pushed the saturated gauze into the wound. The pressure ulcer was the size of a half dollar on Resident #8's coccyx. It was deep, at least an inch, with tunneling all around with the depth unable to be seen. The tissue was red and healthy. There was no odor. There was a small amount of slough (yellow tissue) near the upper right corner of the wound. The surrounding tissue was sheared on the right side, but was in the later stages of healing. The nurse removed the backing from the dressing and covered the entire area with it. The surveyor asked if Resident #8 was on any kind of pressure relieving mattress. Staff L, CNA confirmed it was a regular mattress. After repositioning and covering Resident #8 up, Staff L, CNA removed her PPE and washed her hands in the sink. The nurse removed his PPE and washed his hands in the sink. He gathered the supplies, including the scissors, the hypochlorite solution, and the wound cleanser and exited the room. He didn't clean the scissors or the bottles with the solutions in them. He removed his keys from his pocket and opened the treatment cart and returned the contaminated supplies to a drawer. On 7/8/20 at 4:57 p.m. an interview was conducted with the DON. She said the nurse is responsible for making sure those things happen (treatment orders) when the patient gets admitted . She said it's her responsibility to check behind them. The surveyor asked if the DON thought an air mattress was indicated for Resident #8. She agreed an air mattress should be used. Review of the policy, Dressing Change, revised 12/6/17, revealed the following information: Policy: A clean dressing will be applied by a nurse to a wound as ordered to promote healing. Sterile dressing will be used only if specifically ordered. Procedure: Identify resident. Explain procedure, provide privacy. Assemble equipment as needed for dressing change: gloves wound cleanser/normal saline tape gauze scissors applicators bag for dressing disposal per universal precautions applicable treatment medications Place supplies on prepped work surface perform hand hygiene apply gloves remove and dispose of soil dressing remove gloves perform hand hygiene apply gloves evaluate wound for type, color, amount of drainage cleanse wound as ordered, dispose of gauze remove gloves and perform hand hygiene apply treatment as ordered and clean dressing discard gloves and perform hand hygiene document in medical record
F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, document review, policy review, and USDA (United States Drug Administration) guidelines the facility did not ensure the temperature in a medication refrigerator met safe standards for refrigerated medications in one refrigerator on the West wing of four medication refrigerators, and that temperature logs were maintained for one medication refrigerator (on the West wing) of four medication refrigerators, and that a controlled substance was secured appropriately in the medication refrigerator on the West nursing unit, of four medication refrigerators. Findings included: On 7/7/20 at 12:35 p.m. an observation was conducted with the DON in the medication room near the West wing nursing station. The thermometer in the medication refrigerator was 68 degrees Fahrenheit. The DON confirmed the reading and photographic evidence was obtained. There was a plastic transparent box on one of the shelves with a plastic break away lock containing [MEDICATION NAME] solution vials. There was not a lock on the refrigerator. The [MEDICATION NAME] container was also not secured to a shelf. The DON removed the [MEDICATION NAME] from the refrigerator. In an interview during the observation the DON said the narcotics should be behind two locks. The shelves were full of IV (intravenous) medications and insulins. There was a temperature log on the wall dated May 2020. In an interview with the DON during the observation, she said night shift is responsible for cleaning the refrigerators and maintaining the temperature logs. Upon closer review of the temperature log for the medication refrigerator, it was discovered the form was dated May 2020 and marked 200 hall. A list of the medications being stored in the refrigerator was requested and upon review the following medications were found: 8 TB syringes [MEDICATION NAME]pen [MEDICATION NAME] flex touch insulin three boxes of Interferon Beta-la twelve bags of IV (intravenous) [MEDICATION NAME] boxed insulin kit At 5:10 p.m. on 7/7/20 an interview was conducted with the NHA (nursing home administrator). She said nursing staff clean the refrigerators and completes the temperature logs. The surveyor shared the concern related to the date on the temperature log. The NHA said obviously that's a problem. The DON, who was also present during the interview said 'that's a room temperature log, not a refrigerator log. The surveyor pointed out that some of the temps were 39 degrees F so it couldn't be a room temperature log. The DON said there wasn't a log for June or July. She confirmed the temperature log was dated May 2020. On 7/8/20 at 9:25 a.m. an interview was conducted with the consultant pharmacist. The consultant pharmacist said she visits the facility once a month. She said she hasn't been there since March because of Covid. The consultant pharmacist said the leadership at the facility has changed so much that's it's hard to get them to follow up on anything. That small refrigerator should have been replaced. It's been going on for months. The consultant pharmacist said she spoke to the two previous DONs and the administrator. The refrigerator was not ideal for medication storage. They know it's a problem. She said she has seen it with the ice from the freezer dripping down into the refrigerator. The temperature has been an issue. It was probably toward the end of 2019 when she first brought it to their attention. The surveyor asked what the potential affect on the medication was. The consultant pharmacist replied that it depends on the medication. They may have lost their potency. Some are probably no longer able to be administered. I would say they need to contact the pharmacy to exchange the medications ASAP(as soon as possible). On 7/8/20 at 9:35 a.m. an interview was conducted with the plant operations and maintenance director. He said they have a company that does repairs on the equipment. Staff contacts the maintenance director if something isn't working, usually by phone. Everybody has his phone number. He would then contact the servicer. The customer service representative then sends a technician out to assess the problem. They give us a quote, which is sent to corporate for approval, and then someone comes out to finalize repairs. The maintenance director reported that he was not aware there was a problem with the medication refrigerator. He just heard about it yesterday. He said he just bought six new refrigerators since we made the COVID unit. He has not replaced that refrigerator yet. No one has told him there was a problem with that refrigerator. He said he is the person they would report a concern to. Staff would report a problem to the unit manager on that wing, and she would report it to him. It will be replaced today. He said he will put a lock on the refrigerator with a coded combination pad lock. On 7/8/20 at 10:00 a.m. in a follow up interview with the DON she said she was only aware there was a problem since yesterday. No one ever reported there was an issue with the refrigerator. Review of the pharmacy policy, Delivery and Storage of Medications and Supplies, revised 5/1/16, reflected the following: Considerations: 1. Certain medications and

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F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) solutions require refrigeration and/or protection from light to ensure safety and efficacy. 2. Staff receiving the delivery of medications, solutions, and supplies from the pharmacy must ensure that all products are promptly and properly checked for appropriate storage at the facility per pharmacy instructions. 4.1 Infusion products with additives compounded by the pharmacy must be refrigerated until shortly before the time of the infusion unless otherwise specified. 4.2 The refrigerator temperature should be between 36 and 46 degrees Fahrenheit to maintain stability. 8. Controlled medications will be stored in accordance with facility policy, according to law and regulation. The following information was found at https://www.fsis.usda.gov/wps/portal/fsis/topics/food-safety-education/get-answers/food-safety-fact-sheets/safe-food-handling/freezing-and-food-safety/CT_Index: Freezer - Refrigerator Temperatures The temperature in the refrigerator should be set at 40 F or below. Check the refrigerator temperature with an appliance thermometer.
F 0867 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and policy review the facility did not ensure the plan of correction was effectively implemented for F867, Treatment and Services to Prevent/Heal Pressure Ulcers cited at a scope and severity of G on a complaint survey ending on 7/13/20, with a correction date of 8/17/20, related to lack of appropriate hand hygiene during dressing changes observed on revisit for three (#1, #2, and #3) of three residents reviewed. Findings included: 1) The complaint survey conducted on 7/8, 7/9, and 7/13 reflected the following findings: A resident admitted to the facility with a [DIAGNOSES REDACTED]. Treatments were not initiated, and the impairment progressed to an unstagable pressure ulcer of the coccyx on 6/15/20, identified by an agency nurse, who notified the physician and the Director of Nurses (DON), and implemented a treatment. Additionally, there weren't any assessments in the medical record indicating a description of the wound size, type, drainage, or progress. Another resident readmitted to the facility with a [DIAGNOSES REDACTED]. During an observation of a dressing change on 7/8/20, the surveyor confirmed with a CNA the did not have an ordered air mattress on the bed and during the wound care observation, the nurse exited the room after providing the treatment with a bottle of wound cleanser, Dakin's solution, and a pair of scissors, which he returned to the treatment cart. 2) The plan of correction accepted on 8/17/20 , indicated under Element 3 the facility dressing change policy has been reviewed by a licensed nurse and deemed appropriate. Licensed nurses were reeducated on the facility dressing change policy. Review of Element 4 reflected that the DON or designee will audit a minimum of 10% of the residents weekly to ensure change of conditions which require wound care have been identified and treatment orders obtained. The DON and/or designee will audit a minimum of 5 wound care treatments to ensure dressings are changed per the facility Dressing Change policy. Any concerns will be addressed upon finding. The DON and/or designee will report trends to QAPI (Quality Assurance Performance Improvement) monthly until compliance is sustained times three months. 3) During the revisit survey conducted on 9/24/20 to 9/28/20, observations during dressing changes were conducted on 9/24/20 and the following findings were made: Resident #1 was admitted to the facility with a [DIAGNOSES REDACTED]. Review of the most recent wound consultant progress note dated 9/19/20 reflected a left buttock stage 3 pressure ulcer. Review of the physician's orders [REDACTED]. At 11:15 a.m. on 9/24/20 an observation was conducted during a pressure ulcer dressing change with Staff A, RN (registered nurse) and Staff C, CNA (certified nurse's assistant). There was a sign on Resident #1's door indicating droplet and contact precautions. Staff A, RN said Resident #1 was on precautions [MEDICAL CONDITIONS]. Staff A, RN gathered supplies from the treatment cart including wound cleanser, gauze, [MEDICATION NAME] dressing, bordered gauze dressing. Staff A, used wound cleanser to moisten the gauze 4x4's and placed them on top of all the other supplies for the treatment. She returned the wound cleanser to the treatment cart. Staff A, RN and Staff C, CNA donned the indicated PPE (personal protective equipment) indicated on the signs on the room door, including a mask, goggles, gown, and gloves. Staff A, RN entered Resident #1's room after requesting permission to enter. Staff A, RN placed the bordered gauze in it's wrapper on top of a tissue box on the bedside table. Then she placed the rest of the supplies on top of it. Staff C, CNA assisted with removing Resident #1's brief. Staff C, CNA cleaned Resident #1's peri area and groin which was covered in barrier cream. The brief was wet, but not saturated. Staff C, CNA assisted Resident #1 to turn to her left side for the treatment. There was a small bm (bowel movement) on Resident #1's anal area and inner buttocks. Staff A, RN used wet wash cloth to remove the bm and clean Resident #1's anus and buttocks. Then Staff A, RN removed the gloves and placed them in a trash can at the bed side. Staff C, CNA removed the brief and disposed in a trash can. Then she removed her gloves and went to the bathroom where she washed her hands in the sink and put on clean gloves. She brought clean gloves to Staff A, RN, who put them on without washing her hands or performing any hand hygiene after performing incontinence care. Staff A, RN used some gauze with the wound cleanser to clean the pressure ulcer on Resident #1's left buttock. The wound was the size of a pencil eraser with a bright red, granulating wound bed. There was a a small amount of clear drainage. The wound was 1 mm (millimeter) deep. No odor present. There wasn't a dressing present on the pressure ulcer. Staff A, RN said the dressing was stuck in the brief. Staff A, RN disposed of the used gauze in the trash can. Then Staff A, RN opened the collagen dressing. She did not perform any hand hygiene or remove her gloves after cleaning the wound. Then Staff A, RN opened the [MEDICATION NAME] dressing and placed it over the collagen. Next, Staff A, RN opened the bordered gauze dressing and covered the pressure ulcer. Then Staff A, RN and Staff C, CNA placed a clean brief on Resident #1. Staff A, RN disposed of the wrappers from the dressings in the trash can. Staff A, RN assisted with adjusting the sheet and blankets on Resident #1. Staff A, RN and Staff C, CNA removed the PPE and washed their hands in the bathroom sink. Resident #2 was admitted to the facility with a [DIAGNOSES REDACTED]. Review of the most recent wound consultant progress note in the medical record, dated 9/19/20 revealed a stage 4 pressure ulcer of the sacrum. A review of the physician's orders [REDACTED]. Pat dry, apply kerlix moistened gauze, cover with dry dressing. Dakin's (1/4 strength) solution 0.125% apply to sacrum topically every evening shift for wound care and apply to sacrum topically as needed for wound care Further review of the physician's orders [REDACTED]. Staff A, RN gathered supplies from the treatment cart including wound cleanser, Dakin's solution, gauze, and a bordered gauze dressing. Staff A, RN opened and labeled the dressing and returned it to the wrapper. Staff A, RN poured some of the Dakin's solution in a medication cup. Then Staff A, RN sprayed the gauze with wound cleanser. After retuning the Dakin's and wound cleanser to the treatment cart, Staff A, RN entered the room wearing clean gloves and carrying the supplies. Staff A, did not perform any hand hygiene prior to putting the gloves on. Staff A, RN placed the dressing in the wrapper on top of the bedside table. Then Staff A, RN placed the rest of the supplies on top of the dressing. Staff A, RN removed the brief tabs from Resident #2 and folded it up between Resident #2's legs. Then Staff A, RN removed the PEG tube dressing from Resident #2's PEG tube insertion site, without removing her gloves and performing had hygiene. After placing it in a trash can, Staff A, RN used a dry wash cloth to wipe Resident #2's groin area. Staff A, RN said the brief was dry. Next Staff A, RN turned Resident #2 to her left side. There wasn't a dressing on the sacral wound. Staff C, CNA who had come in the room to assist with the treatment, said the dressing came off with the last brief change. The sacral wound was the size of a half dollar with healthy tissue present in the wound bed that was beefy red. There was 1-2 mm (millimeters) of tunneling at 5:00 on the wound, and there was no odor present. Staff A, RN did not remove her gloves and perform hand hygiene before cleaning the wound with the wound cleanser moistened gauze. After disposing of the gauze she had used to clean the wound, Staff A, RN placed some gauze in the Dakin's solution in the medication cup. Staff A, did not remove her gloves and perform hand hygiene after cleaning the wound. Staff A, RN put the Dakin's moistened gauze on the wound bed. Then Staff A, RN covered the pressure ulcer with the bordered gauze dressing. Next, Staff A, RN replaced Resident #2's brief. Then Staff A, RN removed her gloves and put them in the trash can at the bed side. She did not perform any hand hygiene. Staff A, RN exited the room and went to the treatment cart. She removed the keys from her pocket and opened a drawer and removed scissors. Then Staff A, RN used the scissors to cut an opening on one edge of the adhesive dressing for the PEG tube. Then Staff A, RN returned the now contaminated scissors to the drawer. Then Staff A, RN put on a pair of gloves without performing any hand hygiene. Staff A, RN opened and dated the dressing for the PEG tube with a sharpie. Next, Staff A, RN entered the resident's room, removed the covers, and placed the dressing on the PEG site. She did not clean the PEG tube site before applying the dressing. She returned the covers to Resident #2, removed the gloves and washed her hands in the bathroom sink. Resident #3 was admitted to the facility with a [DIAGNOSES REDACTED]. Review of the 9/19/20 wound consultant progress note indicated a left heel unstageable pressure ulcer. Review of the physician's orders [REDACTED]. Cleanse wound to left heel with Dakin's 0.25%, apply moistened gauze and cover with dry dressing. Dakin's (1/2 strength) solution 0.25% Apply to left heel topically every day shift for wound care. Cleanse wound to left heel with Dakin's 0.25%, apply moistened

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F 0867 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) gauze and cover with dry dressing. On 9/24/20 at 12:15 p.m. an observation was conducted during a pressure ulcer dressing change with Staff A, RN and Staff B, CNA. Staff A, RN had already prepped the treatment supplies on top of the treatment cart including Dakin's solution, bordered gauze dressing, gauze, and a medication cup. Staff A, RN was wearing gloves. She opened and dated the bordered gauze dressing and returned it to the wrapper. She removed scissors from the treatment cart and cut the corners on the bordered gauze dressing and gauze for packing. She returned the scissors to the medication cart. Then Staff A, RN poured some Dakin's solution into the medication cup. Next, Staff A, dipped some gauze into the Dakin's solution and placed the moistened gauze on top of the dressing wrapper with some more gauze. Then Staff A, RN brought the supplies to Resident #3's room and placed them on the bedside table on top of the dressing wrapper. Staff A, RN removed Resident #3's covers from his feet, then she removed the dressing from Resident #3's left heel. Staff A, RN did not change gloves or perform any hand hygiene before staring the treatment. The dressing was dated 9/23. There was some brown and red drainage present on the dressing. There wasn't an odor. The wound on his left heel covered the entire heel. The wound bed was larger than a half dollar with necrotic (dead) tissue surrounded by pink healthy tissue, and a small area of granulation on the interior area of the heel. Staff A, RN disposed of the dressing. She did not change her gloves or perform hand hygiene. Staff A, RN cleaned the wound with the Dakin's moistened gauze. Then Staff A, RN removed the gloves and put on a clean pair. Staff A, RN did not perform any hand hygiene. Staff A, RN dipped some more gauze in the Dakin's solution and applied it to the pressure ulcer. Then Staff A, RN applied the adhesive dressing to the entire heel. Staff A, RN replaced replaced Resident #3's sock and covers. Then Staff A, RN and Staff B, CNA removed their gloves and washed their hands in the sink. At 12:40 p.m. on 9/24/20 in an interview with Staff A, RN she agreed it would have been better to remove her gloves and perform hand hygiene after changing a brief before beginning the treatment. She said she washed her her hands before the dressing changes. She said she is prn (as needed) and only works about once a week. She doesn't always do the treatments. She said she had an in-service on dressing changes about a month ago. On 9/25/20 at 9:38 a.m. in an interview with the DON, she said the wound care nurse was not on the pressure ulcer in-service in the survey book, but she signed the handwashing in-service on 8/10/20. She received an in-service yesterday. The DON provided the surveyor with the in-service signed by Staff A, RN and dated 9/24/20. The DON reported the facility has also contacted a wound care company to come out and train all the nurses. Review of the Education In-service Attendance Record dated 8/10/20 for Handwashing showed Staff A, RN was in attendance. The sign in sheet for Dressing change Education In-service and Attendance Record dated 8/13/20 showed Staff A, RN had phone education. Review of the policy, Dressing Change, revised 12/6/17, revealed the following information: Policy: A clean dressing will be applied by a nurse to a wound as ordered to promote healing. Sterile dressing will be used only if specifically ordered. Procedure: Identify resident. Explain procedure, provide privacy. Assemble equipment as needed for dressing change: gloves wound cleanser/normal saline tape gauze scissors applicators bag for dressing disposal per universal precautions applicable treatment medications Place supplies on prepped work surface perform hand hygiene apply gloves remove and dispose of soil dressing remove gloves perform hand hygiene apply gloves evaluate wound for type, color, amount of drainage cleanse wound as ordered, dispose of gauze remove gloves and perform hand hygiene apply treatment as ordered and clean dressing discard gloves and perform hand hygiene document in medical record Review of the policy, Hand Hygiene, dated 5/10/19 reflected the following information: Overview: The CDC defines hand hygiene as cleaning your hands by using either handwashing (washing with soap and water), antiseptic hand wash, or antiseptic hand rubs (i.e. alcohol-based sanitizer including foam or gel). Purpose: To reduce the spread of germs in the healthcare setting. Process: Hand hygiene should be performed; Before initiating a clean procedure Before and after patient care After contact with blood, body fluids, or excretions, mucous membranes, non-intact skin, or wound dressings After contact with inanimate objects (including medical equipment) in the immediate patient vicinity When hands are moved from a contaminated body site to a clean body site during patient care After glove removal Review of the policy, Performance I improvement (Quality Assurance), dated 8/23/2017, revealed the following: Policy: The facility and organization to have an ongoing performance improvement program with a design and scope that is ongoing and comprehensive dealing with a full range of services offered by the facility including the full range of departments that addresses all aspects of care. The design and scope of the program to systematically monitor and evaluate the quality and appropriateness of resident care, pursue opportunities to improve resident care, resolve identified problems and identify opportunities for improvement. Performance improvement program supports the overall goals of the facility in the organization and [MEDICATION NAME] both outcomes and processes relevant to these outcomes with the objective of improving the organizations performance. Procedure: The facility executive director is accountable for the overall implementation and functioning of the performance improvement programs. This may include training on quality assurance and improve performance improvement, ensuring resources are provided as needed. The executive director is responsible for the program to be a coordinated effort among all departments and services within the organization that involves leadership working with input from facility staff, as well as residents and families as appropriate. Key aspects of care, facility practices and quality-of-life may include but are not limited to: Medical care clinical care medical records Important functional areas may include but are not limited to: Resident assessment quality of care potential adverse events continuity of care infection control Review of activities may include but not limited to: Infection control incident/accident reports resident/family complaints/satisfaction interdisciplinary care planning wound care/prevention staff orientation, in-service and competence physician services The facility to identify areas for continuous quality monitoring and monitoring tools to be used. These monitoring activities should focus on those processes that affect resident outcomes most significantly. This ongoing monitoring is used to establish the facilities baseline and the predictability of various outcomes. The following sources of data may be used, but not limited to: Resident medical records direct observation department logs 24 hour reports mock surveys accident trending resident/family complaints committee minutes survey process 24 hour report resident Council medical record reviews compliance surveys performance indicators The performance improvement committee to review and coordinate the proposed activities and identify the priorities for the coming year and as events are identified. The performance improvement committee to create a master performance improvement calendar. This calendar may change during the year as priorities change. Criteria for selecting aspects of care for improvement are based but not limited to: Facilities goals/objectives, mission high-volume -the aspect of care occurs frequently or affects large numbers of residents. Identification of potential or actual adverse events. High risk - residents are at risk of certain consequences or are deprived of substantial benefits if the care is not provided correctly, and in a timely fashion or on proper indication. Problematic - the aspect of care has tended in the past to produce problems for staff or residents. High cost - the aspect of care involved a high cost either of financial or personal utilization. Regulatory previous or current regulatory Items or identified concerns. Once an aspect of care or indicator has been identified or selected, the performance improvement committee will: Assign a performance action team to address the identified area, examine, and improve the identified need. Identify the goals of the performance improvement project. These goals must be objective, measurable and based on current knowledge and or clinical experience. Identify the goals of the performance improvement project. These goals must be objective, measurable and based on current knowledge and or clinical experience. These indicators should measure those appropriate dimensions of performance that address: Appropriateness effectiveness timeliness safety respect and caring for residents efficiency consistency with other program/treatments/staff Determine how/where to obtain necessary information, the appropriate sample size to be used, time frames and acceptable thresholds. Determine roles and responsibilities of the performance improvement action team. The performance improvement action team to document findings, initiate corrective actions as directed and present results to the performance improvement committee. Documentation to include but not limited to: What is significance of study decision making process \ methodology findings: trends, percentages, etc. Recommended improvement activities including follow up The performance improvement QAPI committee to advise individual services in performance action teams on methodology, data collection, and data analysis and review all final reports and recommendations. The goals, plans and results of the facilities performance improvement activities to be communicated to all staff by means of staff meetings, changes in policy and procedure or in-service training. The performance improvement program to be evaluated annually by the performance improvement committee to assess that the programs activities have a chief substantial performance improvement. The performance improvement QAPI committee has the responsibility for designing and implementing corrective action plans as needed to resolve identified resident care/service problems. This is accomplished within local, state, federal and corporate guidelines as well as fiscal restraints. Improvement plans to contain: What is to be changed when and how correct of action to be implemented who is responsible for the implementation of the corrective action what time interval is set for reassessment in order to evaluate the impact of action taken improvement plans and effectiveness of actions to be documented in the committee minutes. On 9/27/20 at 11:15 a.m. an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105520	A. BUILDING _____ B. WING _____	**07/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CONSULATE HEALTH CARE OF BRANDON	**701 VICTORIA ST BRANDON, FL 33510**

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F 0867 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 4) interview was conducted with the NHA (nursing home administrator). The NHA said she is the QAPI chairperson and the risk manager. Staff A, RN is a prn nurse. She called in the next day. The NHA said she knew the treatments didn't go well based on that. The DON said she was going to do a disciplinary action with her. We won't use her again for wounds. She is prn. She might not be the right person for it.