STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105474	A. BUILDING _____ B. WING _____	**08/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CONSULATE HEALTH CARE OF VERO BEACH	**1310 37TH ST VERO BEACH, FL 32960**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide care and services to promote wound healing. This failure affected 1 of 3 sampled residents (Resident #1). The findings included: Clinical record review conducted on 08/12/20 revealed Resident #1 was admitted to the facility on [DATE] with multiple medical problems including septic left knee arthritis status [REDACTED]. Minimum Data Set, admission assessment with reference date 05/22/20 documents the resident was assessed as moderately impaired for skills of daily decision making, had no behaviors, had no pressure ulcers or skin issues upon admission. Care plans initiated for the resident included: The resident has potential impairment to skin integrity related to fragile skin. last revised 06/03/20 documents interventions as keep skin clean and dry and encourage good nutrition and hydration. The resident has potential nutritional problems related to higher body mass index, history of Diabetes, [MEDICAL CONDITION], and significant weight decrease last revised on 07/01/20 documents interventions as provide supplements as ordered. The record has no evidence of completed weekly skin checks, scheduled every Thursday. physician's orders [REDACTED]. Physician Notes dated 06/25/20 documents, The resident has functional decline due to multiple medical problems, left knee [MEDICAL CONDITION] joint disease. Left knee with mild effusion without warm or [DIAGNOSES REDACTED]. The resident received [MEDICATION NAME][MEDICATION NAME] and [MEDICATION NAME] injection to the left knee to treat persistent severe left knee discomfort. Will monitor responses and continue palliative care. The record indicates Resident #1 developed pressure wounds on 06/25/20 and was seen by the wound doctor on 06/26/20. physician's orders [REDACTED]. Physician Wound Care Notes dated 07/03/20 documents wound to left knee, duration greater than one day, measures 0.5 cm in length, 0.5 cm in width and 0.2 cm in depth. Moderate serous sanguineous drainage, Treatment plan Alginate Calcium with silver, cover with dry protective dressing, apply once a day for 30 days. Non pressure skin condition record dated 07/03/20 documents the resident developed a wound to left knee measures 0.5 cm in length, 0.5 cm in width and 0.2 cm in depth, small to medium amount of drainage, serous drainage, yellow and red, area with redness and irregular edges. Review of the Medication and Treatment Administration Records dated 07/2020 revealed no evidence of treatments provided to the wound to the left knee, from the date of the wound care evaluation, 07/03/20 thru discharge date of [DATE]. There is no evidence the prescribed supplements, Med Pass, Vitamin C, Prostat, Multi vitamins and Zinc were administered from 07/01/20 thru 07/07/20. The clinical record does not contain orders to discontinue the supplements ordered to promote wound healing and minimize weight loss. Interview with The Risk Manager (RM) on 08/12/20 at 10:34 AM revealed the facility has conducted an investigation of the care provided to Resident #1 and determined the care was appropriate with no evidence of neglect. The RM was not able to locate the requested weekly skin assessments, evidence the wound to the left knee was cared for, or evidence the prescribed supplements were administered as ordered and explained I cannot provide you with what I don't have. Interview with The Wound Nurse and The Risk Manager on 08/12/20 at 10:51 AM revealed the wound nurse was asked to see Resident #1 on 06/25/20 as the resident had developed a wound, deep tissue injury to the right heel and redness to the coccyx and thigh region. On 07/03/20, the wound doctor examined the resident and addressed the wound to the left knee, as a skin tear, at this time they were not aware, the primary doctor had given him an injection and the wound was a result of that treatment. The wound doctor assessed the wound and wrote treatment plans with Alginate, but when he learned it was from an injection, the wound doctor decided to let the primary doctor deal with this wound. The wound nurse recalls the primary nurse called the doctor and is not sure what the resolution was at that time. The wound nurse confirmed she did not follow up with either physician to ensure the wound was treated as recommended. The wound nurse stated she does all the wound treatments in the facility and rounds with the wound doctor; acknowledges she did not contact the primary care physician to follow up or notify a supervisor to escalate the need for treatment orders for Resident #1. Interview with the Risk Manager on 08/12/20 at 11:42 AM revealed regarding the wound to the left knee, the primary doctor was called, he stated he was coming to see the patient but never did, so the nurses cannot write treatment orders. The RM confirmed there is no documentation the physician was contacted again, after 07/01/20 and there is no evidence the facility escalated the lack of physician response to ensure treatment orders were in place. Interview with The Primary Care Physician conducted on 08/12/20 at 1:03 PM, revealed Resident #1 had severe pain to the left knee and was treated with steroid injection on 06/25/20. About a week later he received notification that the wound had some drainage. He planned to see the resident the next day but did not, and at all times he was under the impression that the resident was being followed by the wound doctor, so there was no urgency. The wound was being addressed by wound care and is it not unusual to have some drainage after the injection. Days later, the Assistant Director of Nursing called him to report the resident was not doing well and based on the symptoms reported he treated the resident with intravenous fluids, antibiotic and ordered blood work. The resident was transferred to the emergency room . laboratory results dated [DATE] validates the resident was septic with an elevated blood count. Based on record review and interview the facility staff failed to ensure Resident #1's wound to the left knee was treated appropriately and the staff failed to administer supplements ordered to enhance and promote weight gain and wound healing.

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.