STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105919	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WESTMINSTER COMMUNITIES OF BRADENTON WESTMINSTER	**1700 21ST AVE W BRADENTON, FL 34205**

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 0773 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, the facility did not ensure that one (Resident #8), out of two residents sampled for infections, received laboratory services in a timely manner. Despite noted changes in Resident #8's mentation, the facility failed to obtain a urine culture ordered by the physician for over 6 days. Findings Included: Record review of Department Notes, dated 3/4/2020 at 2:55 p.m., revealed Resident alert with increased confusion. Able to convey needs. Resident presents with chest congestion and expiratory rattles. At 5:14 p.m., the Resident left the Facility via EMS (Emergency Medical Services) to the hospital for evaluation and treatment due to a change in condition. Review of Resident #8's Admission Record revealed that he was admitted on [DATE] with [DIAGNOSES REDACTED]. His Minimum (MDS) data set [DATE] revealed: Section C: Cognitive Patterns: Brief Interview for Mental Status (BIMS) score of 11, which indicated Resident #8 had moderate cognitive impairment. Section H: Bladder and Bowel revealed the Resident was frequently incontinent of urine and bowel. Review of a Bowel and Bladder Assessment, dated 12/02/2019, revealed that Resident #8 had urinary incontinence and required total assistance for toileting/incontinence care. A review of Resident #8's Care Plan dated 12/02/2019, revealed potential for complications for episodes of incontinence related to decreased physical mobility, weakness, [DIAGNOSES REDACTED]. Interventions included: Observe for any sign and symptoms of urine infection such as foul odor urine, pain in urination, changes in condition, mental status, decrease appetite, elevated temperature and notify nurse/medical doctor as needed. An interview on 3/5/2020 at 11:17 a.m. with Staff B, a Certified Nursing Assistant (CNA), confirmed that Resident #8 was incontinent. Staff B stated that the Resident had intermittent moments of confusion and moments of orientation. Staff B said, He will sometimes yell out that he needs to urinate when we are changing him, but he is already wet. Record review of Physician order [REDACTED]. The order was only to be discontinued once a sample was collected. A review of the Family Medicine Admit Note, dated 2/27/2020, revealed that, Resident was seen by wife request. Tells me she feels like he has had a cognitive decline over past few days. Tells me he is achy all over and in pain. Record review of the Administrative Record (e-MAR) revealed that a urine sample was unable to be collected on various dates and times. This includes: 1. Date and time: 2/28/2020 at 6:08 a.m., and 11:04 p.m. 2. Date and time: 2/29/2020 at 6:13 a.m., 1:23 p.m., and 9:45 p.m. 3. Date and time: [DATE] at 6:38 a.m., 12:38 p.m., and 9:49 p.m. 4. Date and time: [DATE] at 5:59 a.m. 5. Date and time: 3/3/2020 at 5:10 a.m. 6. Date and time: 3/4/2020 at 6:30 a.m. 7. Date and time: 3/5/2020 at 5:16 a.m. Interview on 3/5/2020 at 11:20 a.m. with Staff C, a Registered Nurse (RN). Staff C stated (Resident #8) has periods of confusion but around February 25th, he was more and more confused. I notified the doctor. I thought it might be related to depression and attention seeking behavior as he used to be very active but had a stroke and now is in his bed more often. Staff C stated that the UA/C&S was ordered to rule out a urinary tract infection [MEDICAL CONDITION]. The RN stated that a sample was unable to be obtained because the Resident was incontinent and wore briefs, therefore, a straight catheter was necessary to obtain a clean sample for analysis. I sent out two faxes to the doctor about getting a straight catheter sometime last week. We need to have an order in place to do an invasive procedure such as that. Staff C was asked for evidence that the faxes were sent, and she replied, I'm not sure where I put it. Staff C stated that the faxes sent are not saved. An interview was conducted on 3/5/2020 at 11:39 a.m., with Staff A, both a Licensed Practical Nurse (LPN) and the acting Day Supervisor. Staff A stated the Resident was urinating, but staff was unable to obtain a clean sample for the analysis. Staff A was unable to provide documentation of notification to the physician about the facility's inability to collect a clean urine sample for the urine culture. Staff A was unaware of any faxes sent by Staff C to the physician regarding the urine sample. Staff A said (Staff C) She should have entered that into the notes. Staff A acknowledged that there were no notes regarding attempts to obtain a straight catheter order. Staff A said Normally the nurses will let me know if an order is needed for something like a straight catheter. But I was unaware that the Resident needed this. If the doctor does not respond, I will call the doctor directly and obtain a verbal order to cover us until a written order is in place and then enter this into the online notes section. When Staff A was asked why a straight catheter order was not obtained from the doctor while the doctor was in the facility on [DATE], Staff A said, I am not sure. An interview was conducted on 3/5/2020 at 1:02 p.m. with the Director of Nursing (DON). A Registered Nurse Surveyor was also present. The DON stated, if the staff is unable to get in contact with a physician, then we would call their Nurse Practitioner. If we don't hear back from them then we would contact the Medical Director. It also depends on the nature of the call and the level of distress. If the staff cannot get in contact with the people, then they should call me, and I will get in contact with them. The DON stated that there are three locations for notes. The first is the 24-hour nurse to nurse notes that transfer between shifts. The second is in the online system, and the third is the paper chart. When asked if the DON was aware of the UA/C&S for Resident #8 and the need for a straight catheter, they responded, Hum, I'll have to follow up on that and find the paper trail. I was not aware of this order to begin with. I do see notes in there (online system) related to attempts to collect but have to check to see on orders related to the catheter. The Registered Nurse Surveyor asked the DON if they agreed that the staff should have immediately obtained a straight catheter order since it was known that Resident #8 was incontinent, and it would be difficult to obtain a clean urine sample. The DON replied, I agree, you are correct. A review of the facility's policy titled Documentation in Medical Record, revised in February 2019, revealed, Each resident's medical record shall contain enough information to provide a picture of the resident's process through complete, accurate, and timely documentation.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observations, interviews, and policy review, the facility failed to obtain food temperatures in a safe and sanitary manner. The facility did not implement proper sanitation of the metal stem probe thermometer while measuring the temperatures of ready-to-consume food items. Of 50 total residents, the facility identified that 49 of them receive nutrition orally. Findings Included: During the comprehensive kitchen tour on 03/04/20 at 11:15 a.m., Staff D, kitchen aide, began temperature measuring of the ready-to-consume food items. These food items were going to be transferred to the Caf serving area in the Long-Term Care Center for lunch. The Assistant Director of Nutrition was present throughout the temperature measuring process from set-up to completion of transfer. During an observation on 03/04/20 at 11:20 a.m., Staff D began removing various aluminum covered food containers from the hot holding steam case and placed items onto the food prep storage table by the vegetable wash station. Staff A removed the metal stem probe thermometer from the protective

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 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) case, opened and removed an alcohol wipe from a package, and wiped the thermometer. After wiping, Staff A placed the thermometer onto the opened temperature logbook and removed the aluminum foil from the food container. Staff A then picked up the thermometer from the logbook and inserted it through the plastic wrap, which was underneath the aluminum foil, into the food item without re-wiping. Once the thermometer stabilized in temperature, the aide removed the thermometer, placed it onto the table, and wrote the finale temperature into the logbook. Staff D completed this series of steps of wiping the thermometer, placing it onto the logbook, and then inserting it into the food items without re-wiping between the fortified mashed potatoes, pasta with butter, Italian green beans, pork tenderloin, and the chicken marsala. After completing the temperature measuring, the aide placed the food items onto the brown transfer cart. An interview on 03/04/20 at 11:30 a.m. with Staff D revealed that the purpose of wiping the thermometer with the alcohol wipe between food items was to sanitize the equipment. When asked if the temperature logbook was a sanitary storage surface, Staff A responded no. During an observation on 03/04/20 at 11:30 a.m., Staff D begin temperature measuring of the pureed ready-to-consume food items. Staff A placed the food containers from the hot holding steam case onto the table countertop, wiped the thermometer with an alcohol wipe, removed the aluminum foil, maintained the thermometer in their hand, and inserted the sanitized thermometer directly into the food item. Staff D completed this series of steps between the ground chicken, pureed beets, and ground pork. An interview on 03/04/20 at 1:32 p.m. with the Director of Nutrition said that the process to food temperature measuring was to, calibrate the thermometer, wipe it (with an alcohol wipe), and then stick it into the food for 10-15 seconds to measure the temperature. Then we would take it out, wipe it, and stick it to the next food. The Director of Nutrition stated that their expectation for staff is that the thermometer would be wiped with an alcohol wipe, hold the thermometer in their hand and then place it directly into the product. The Director of Nutrition said However, if the surface the thermometer is placed on is clean and sanitized between usage then that would be fine. But what I would do is hold the thermometer, wipe it, stick it into the food, and measure the temperature that way. Policy review of Food Safety Requirements, revised June 2016, revealed under the header Policy Explanation and Compliance Guidelines, number 1, Food safety practices shall be followed throughout the facility's entire food handling process. This process begins when food is received from the vendor and ends with delivery of the food to the resident. Elements of the process include the following: Equipment used in the handling of food, including dishes, utensils, mixers, grinders, and other equipment that come in contact with food. Number 6 on the policy revealed, All equipment used in the handling of food shall be cleaned and sanitized and handled in a manner to prevent contamination.