STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105978	A. BUILDING _____ B. WING _____	**10/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GULF SHORE CARE CENTER	**6767 86TH AVE N PINELLAS PARK, FL 33782**

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 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, record review and interviews, the facility failed to ensure that an accurate skin assessment was completed for one (#3) of 10 sampled residents. Findings include: On 10/01/20 at 12:40 p.m., an interview was conducted with Resident #3. Resident #3 was observed to be in her bed, able to answer questions. She was asked if she had any sores. She stated that she had some sores that she got while she was at the hospital and the staff were putting cream on them. She lowered her pants to expose her lower abdomen to reveal a quarter size open wound area on the lower left side and a dime size open wound area on her right side. The beds of the wounds were pink. Resident #3 was also observed to have a bandage with a 10/01/20 date on her left upper wrist area. On 10/01/20 at 12:45 p.m., Staff A, Registered Nurse (RN) was interviewed. She was observed in the hallway 2 doors down from Resident #3's room with her medication cart. She was asked about Resident #3 and her wounds. She stated that the resident just came over from the East unit, and that the resident had a behavior of picking at her wounds. She stated that she thought that a binder was used to keep her from picking the wounds. She stated that she thought the resident had a treatment before; but, when she reviewed the resident's clinical chart on her computer, she stated there was no treatment at this time for the two wounds on the resident's lower belly. She said she was not sure about the resident's arm. She reviewed the chart and confirmed that the resident had a left forearm skin tear and there was a treatment order for that. A review of Resident #3's Care Plan: Focus area: Resident #3 has a potential for skin impairment/pressure ulcers r/t (related to) impaired mobility, requires staff assist to turn and reposition, urinary catheter, hx of pressure ulcers, fragile skin, [MEDICAL CONDITION]: BLE (Bilateral Lower Extremities)), is obese and at increased risk of breakdown in skin folds, initiated 07/30/20. The goal of the plan: Resident will remain free of any skin breakdown through review date. Interventions included: Observe skin for sx (signs and symptoms) of breakdown during care. A review of a Weekly Skin Check V2, dated as completed on 08/26/20, documented Skin Observations. Abdomen 2 x new open areas on abdomen from resident picking/scratching at skin; and 1 x new open area dorsal side of right hand from resident picking/scratching at skin. A review of a Nursing Comprehensive Evaluation V3, for admission, dated 09/16/20, documented a Skin Evaluation Tool, that documented a description: redness on abdomen around supra pubic site, skin tear to left arm tx (treatment) in place. A review of a Daily Skilled Note V.3, dated 09/24/20, section 3 for Skin, reflected a blank. On 10/01/20 at approximately 1:30 p.m., the ADON (Assistant Director of Nursing) stated that If new skin issues were found, it would show here. A review of Resident #3's Progress notes was conducted for the time period of 09/13/20 through 10/01/20 for documentation of skin wounds on lower abdomen. 09/18/20, 7:31 a.m.: Social Service Note: Readmission .09/16/20 .Brief Interview for Mental Status (BIMS) assessment completed on 09/17/20. BIMS-15. 09/19/20, 2:05 p.m.: Skin is warm/dry. No surgical wound noted. Has wounds present: Right Lower Quadrant (RLQ), Left Lower Quadrant (LLQ). Dressing to wound remains clean, dry, and intact. Skin treatments performed as ordered. 09/20/20, 12: 05 p.m.: Skin warm/dry. No surgical wound noted. Has wounds present: RLQ, LLQ. Dressing to wound remains clean, dry, and intact. Skin treatments performed as ordered. Reviewed through 09/30/20, 3:04 a.m. (last note prior to the 10/01/20 notes). A review of the MDS (Minimum Data Set) Entry tracking Record for Resident #3, dated 09/16/20, section M1040, for documentation of Other Ulcers, Wounds and Skin Problems, Other Problems, section D. Open [MEDICAL CONDITION](s) other than ulcers, rashes, cuts (e.g., cancer [MEDICAL CONDITION]), documented none. On 10/01/20 at 2:40 p.m., an interview was conducted with the Regional RN, ADON, and Staff B, Licensed Practical Nurse (LPN), Unit manager. The Regional RN stated that Resident #3 had been transferred to the hospital on or about 09/15, and she had returned to the facility on [DATE] and was treated as a new admission. The ADON stated that no shower sheets were available for Resident #3 from 09/16/20 thru the date of survey. He further stated that the resident did receive showers, as she did not like bed baths. The Regional RN provided a progress note, dated 10/01/20 at 13:56 (1:56 p.m.), that stated: PRN (as needed) skin sweep was done and resident had red round dry lesion like areas noted to ABD (abdomen) with no drainage or S/S (signs or symptoms) of infection. ARNP (Advanced Registered Nurse Practitioner) aware with new orders received, signed by Staff B, LPN. The DON provided a PRN Skin Check/Nurse, signed by Staff B, LPN on 10/01/20, that documented Resident #3 had a NEW skin impairment that had not been previously noted, which stated: area 14) Abdomen: Red round dry lesion like areas noted to ABD (abdomen). New orders received per ARNP. In addition, the ADON provided a new physician order, dated 10/01/20, 13:53 (1:53 p.m.) [MEDICATION NAME] Ointment 2% (Mupirocin) Apply to abdominal [MEDICAL CONDITION] topically as needed for skin care and apply to abdominal [MEDICAL CONDITION] topically every day shift for skin care apply ointment and leave OTA (open to air). In addition, the ADON provided a copy of Resident #3's physician orders [REDACTED]. Review of the orders reflected a listing: Mupirocin Ointment 2%, apply to open areas on the abd (abdomen) topically everyday shift for open areas r/t (related to) picking/scratching for 14 days, keep open to air. The physician order [REDACTED]. A review of Resident #3's September Treatment Administration Record (TAR), reflected that staff administered the ointment per physician order. Further review of the Treatment Administration Record (TAR) listed a physician order: Perform visual skin check weekly and complete Weekly Skin check V2 on Thursdays/3-11, every evening shift every (Thursday) for preventative skin care. (this was documented to have been completed on 09/24/20, but the form was blank in the skin review area.) No documentation was in the clinical chart for the period between 09/11/20 and the date of survey, 10/01/20, that would indicate the physician had been contacted to inform him that the wounds or [MEDICAL CONDITION] had not closed or healed. On 10/01/20, the Regional Nurse provided a Record of In-Service, dated 03/05/20, that included: Putting new wounds on 24-hour report & notify UM (unit manager), ADON, DON. At 4:00 p.m., the Regional nurse provided a copy of the facility, Comprehensive Assessments and Care Delivery Process, dated 2001, revised December 2016; The Regional nurse stated that there was no skin assessment protocol. At 4:00 p.m., the Regional nurse provided a copy of the facility, Skin Tears-Abrasions and Minor Breaks, Care of, dated 2001, revised September 2013, the policy documented in the Documentation paragraph, page 2, Record the following information in the resident's medical record: 1. Complete in-house investigation of causation. 2. Generate Non-Pressure form (The regional nurse was interviewed, she stated that the Non-Pressure form meant an incident form. Further review of the protocol in the documentation section, #9: When an abrasion/skin tear/bruise is discovered, complete a Report of Incident/Accident. A review of an article, Wound Assessment,(NAME)M. Nagle; Abdul Waheed;(NAME)c Wilbraham, September 11, 2020; accessed 10/06/2020, www.ncbi.nih.gov/gooks/NBK 8/: A wound is damaged or disruption to the skin and, before treatment, the exact cause, location, and type of wound must be assessed to provide treatment. . Clinicians perform wound assessment as a means for determining the appropriate treatment for [REDACTED]. The initial assessment should begin with the following: How: How was the wound created and, if chronic, why is it still open? (underlying etiology) Where: Where on the body is it located? . When: How long has this wound been present? (e.g., chronic or acute) What: What anatomy does it extend? (e.g., epidermis, dermis, subcutaneous tissue, fascia, muscle, tendon, bone, arteries, nerves) What: What comorbidities or social factors does the patient have which might affect which might affect their ability to heal the wound? . Generally, ongoing nursing and clinician assessments and monitoring of wounds are similar: Identify the location of the wound Determine the cause of the wound Determine the stage of the wound . Evaluate and measure the depth, length,

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 0641 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) and width of the wound . Evaluate the wound bed . Evaluate for signs and symptoms of infect-warm, pain, odor, delayed healing. Assess pain