STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105839	A. BUILDING _____ B. WING _____	10/01/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TERRACE OF KISSIMMEE, THE	221 PARK PLACE BLVD KISSIMMEE, FL 34741

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, interview and record review the facility failed to ensure accuracy of the quarterly Minimum Data Set (MDS) assessment for prognosis for 1 of 1 resident reviewed for hospice, (#33) and failed to ensure the MDS assessment accurately reflected respiratory treatments for 1 of 4 residents reviewed for respiratory care (#11), out of a total sample of 36 residents. Findings: 1. On 9/28/20 at 11:52 AM, resident #33 was observed resting in bed on her right side. According to the facility census information, the resident's payor source was hospice. Review of the MDS quarterly assessment with assessment reference date (ARD) 7/6/20 did not identify resident #33 as having less than 6-month life expectancy. The hospice Medical Doctor (MD) certified on 1/2/20 that resident #33 was terminally ill and had limited life expectancy of 6 months or less if the terminal illness ran its' normal course. On 10/1/20 at 2:27 PM, Registered Nurse (RN) MDS Coordinator said resident #33 had hospice care since 1/2/20 to present date and the most recent MDS assessment was not accurate for life expectancy. As the RN who signed off on the assessment, I missed this one. The MDS RN verified that section J 1400 Prognosis should have been yes life expectancy of less than 6 months. 2. Resident #11 was admitted to the facility on [DATE], and readmitted on [DATE]. Her [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. The quarterly MDS assessment with assessment reference date 6/21/20 revealed that in Section: O, special treatments, procedures, and programs, oxygen therapy was not assessed. On 09/28/20 at 11:31 AM and at 4:00 PM, resident #11 was observed receiving oxygen (O2) via nasal cannula at 2 liters per minute (LPM). A care plan for At risk for respiratory distress related to SOB requiring oxygen therapy, was created on 12/03/18, and revised on 9/29/20. An intervention included, administer oxygen as ordered, observe oxygen precautions. On 09/28/20 at 4:03 PM, Registered Nurse (RN) C stated the resident was on O2 2 LPM continuously. On 10/01/20 at 11:13 AM and 12:39 PM, the RN MDS coordinator stated that MDS assessments were completed by reviewing the resident's physician orders, the resident's electronic medical record, observation of the resident, and a seven day look back of their medical record. The RN MDS coordinator stated that oxygen would be assessed if the resident used it during the seven day look back period. A review of the resident's medical record during the seven day look back period for the MDS assessment with ARD 6/21/20 was conducted by the RN MDS coordinator. She stated that resident #11 received oxygen during the look back period, and that oxygen was not assessed, and should have been assessed as being in use.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop and implement a patient-centered care plan for smoking for 1 of 36 sampled residents, ((#93). Findings: Resident #93 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the facility's smoking policy and procedure revealed it was dated and signed by the resident on 8/17/2020. A review of the Admission Minimum Data Set (MDS) assessment with an assessment review date of 8/21/2020, read, Other Health Conditions . J 1300. Current Tobacco Use: Yes. A review of the care plans for resident #93 revealed there was not any comprehensive, patient-centered care plan for smoking. On 9/29/2020 at 4:11 PM, resident #93 stated he went out to smoke accompanied by a facility Certified Nursing Assistant (CNA). on 09/29/20 at 4:16 PM, CNA A stated resident #93 liked to smoke often and requested to smoke approximately 5 times during her shift from 3 PM - 11 PM. On 09/30/20 at 2:14 PM, Licensed Practical Nurse (LPN) B stated resident #93 usually went out to smoke at least 3 to 4 times during her shift from 7 AM-3 PM. On 10/01/2020 at 10:46 AM, the Social Services Director (SSD) stated she was aware resident #93 was a smoker, He is on our list. She stated he went out to smoke with supervision of a CNA and he was a safe smoker. She said, He should have a care plan developed for smoking but that is done by Minimum Data Set (MDS) staff. On 10/01/2020 at 11:12 AM, Registered Nurse (RN) MDS Coordinator said, Once we know someone is a smoker, we initiate a care plan. The resident care plans were reviewed with the RN MDS Coordinator and she noted that a care plan for smoking was not initiated for resident #93. She said, Yes, unfortunately, I put in a care plan for him today (10/01/2020) because one was not put in previously. She stated resident #93 had been in the facility since 8/14/2020. She said that a baseline care plan was completed, . but unfortunately smoking was not on that either. Review of the facility smoking risk assessment, dated 8/17/2020, read, Plan of Care, Indicate Plan of Care action taken: Initiate Plan of Care.
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 obtain a physician's order for oxygen therapy for 1 of 2 residents, (#76) and failed to follow the physician's orders and protocol for weekly oxygen tubing change for 1 of 2 residents sampled for oxygen therapy, (#11). Findings: Resident #76 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A nursing progress note dated 9/28/2020 at 6:49 AM, read, . Vitals are stable, O2 (oxygen) sat (saturation) 97 percent with 2 L (liter) oxygen via NC (nasal cannula) . On 09/28/2020 at 11:10 AM, resident #76 was observed receiving oxygen via nasal cannula with the oxygen concentrator set at 2 Liters per minute (LPM). A review of the resident's physician's orders from admission 8/17/2020 to 9/30/2020, revealed no order for oxygen therapy. On 09/30/20 at 1:50 PM, resident #76 was observed receiving O2 via NC and the oxygen concentrator was set at 2.5 LPM. On 9/30/2020 at 1:50 PM, Licensed Practical Nurse (LPN) B stated she took resident #76's vital signs at 7:30 AM, with the blood pressure at 117/ 94, pulse 85, respirations 18, temperature 96.9, oxygen saturation 96% with 2.5 L O2 NC via oxygen concentrator. The resident's Physician Order Sheet (POS) was reviewed with LPN B. She stated there was no order for O2. Resident #76 was observed with LPN B. LPN B stated that the resident was receiving O2 at 2.5 LPM. On 09/30/2020 at 2:32 PM, the Director of Nursing (DON) said, You have to have a doctor's order unless they are having distress you put it on and obtain an order afterwards. The DON reviewed the physician's orders for resident #76 and stated there was no order for oxygen therapy. She did not explain how the resident received oxygen therapy without a doctor's order. The facility's policy Oxygen Usage , revised July 2016, and updated 7/2020, read, The facility will ensure that oxygen will be administered in compliance with current standards of practice . 1. oxygen shall be administered only upon the written order of a person duly licensed and authorized to prescribe such a drug in this state . 2. Resident #11 was admitted to the facility on [DATE], and readmitted on [DATE]. Her [DIAGNOSES REDACTED]. A physician's order dated 12/15/19 read, Change O2 (oxygen) tubing every Thursday. Observations on 09/28/20 11:31 AM, and at 4:00 PM showed resident #11 received oxygen via a nasal cannula. A blue label was on the oxygen tubing, and read, Change Thursday and was dated 4/30/20. On 09/28/20 at 4:03 PM, the resident's oxygen tubing was observed with registered nurse (RN) C. He

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 0695 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) stated the date documented on the tubing read 4/30/20. RN C said the tubing should have been changed weekly. On 09/28/20 at 4:30 PM, the Director of Nursing (DON) was made aware of findings for resident #11's oxygen tubing. The DON stated that O2 tubing should be changed weekly. On 09/30/20 at 12:28 PM, the DON stated that tubing change was done by the Central Supply personnel, but placed and checked by nursing staff. The DON stated, .nursing was responsible to check on all aspects of resident care. 09/30/20 at 12:39 PM, the Assistant Director of Nursing (ADON)/Infection Control nurse, stated there was potential for infection if the tubing such as nasal cannula were not changed as recommended/ordered. The facility's policy Oxygen Usage revised July 2016 read, Oxygen tubing/cannulas will be changed when visibly soiled .in accordance with manufacture instructions, when available.