STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105522	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LEHIGH ACRES HEALTH AND REHABILITATION CENTER	1550 LEE BOULEVARD LEHIGH ACRES, FL 33936

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 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of facility policy and staff interview, the facility failed to have an accurate record keeping of resident's State of Florida Do Not Resuscitate (DNR) Order forms for 3 (Residents #371 and #372) of 51 residents sampled for advanced directives. This had the potential for residents to receive cardiopulmonary resuscitation when they did not want it. The findings included: The facility policy 12.01.024, Standards and Guidelines Determination of Code Status, documented the nurse will contact the attending physician and obtain order for full code or DNR per resident or responsible party wishes, the physician will sign and date the State of Florida DNR Order form. A Code Status binder will be maintained at each nurse's station. Copies of the State of Florida DNR Order form will be maintained in the binder. On [DATE] at 11:17 a.m., a medical record review revealed a physician order [REDACTED].#372 had a DNR order. The medical record did not contain a State of Florida DNR Order form signed by the physician. On [DATE] at 11:23 a.m., a review of the medical record revealed a physician order [REDACTED].#371 had a DNR order. The medical record did not contain a State of Florida DRN Order form signed by the physician. A review of the B Unit's DNR book dated 2018, contained 1 DNR of a resident who no longer resided in the facility. The DNR book did not contain a DNR for Residents #371 and #372. A review of the C Unit's DNR book revealed 16 DNRs of residents who no longer resided in the facility. On [DATE] at 10:31 a.m., in an interview the Administrator said, they do audits of the DNRs and said it was unacceptable for the residents not to have a signed DNR on file. On [DATE] at 11:30 a.m., in an interview with the Social Services Director, she said she does weekly audits of the DNRs and will remove the State of Florida DNR Order form from the DNR book if the resident was discharged from the facility or had expired. The Social Service Director said it was the Unit Managers job to update the DNR books. The Social Service Director confirmed there was no copy of the State of Florida DNR order form for Residents #371 and #372 in the DNR book. On [DATE] a 11:52 a.m., in an interview Licensed Practical Nurse Staff I, said if a resident was not breathing and did not have a pulse, she would look at the medical record and in the DNR book at the nursing station to make sure there was a State of Florida DNR Order form. Staff I said the DNR book is updated by the unit manager.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of facility policy, medical record review, resident and staff interview, the facility failed to provide the necessary services to maintain personal hygiene for 1 (Resident #115) of 2 residents sampled for activities of daily living. The findings included: The facility policy 12.07.20.010, Standards and Guidelines Showers/Bathing specified, The standard of this facility to assure that showers/bathing are offered to the residents at least 2 times a week or per resident preference .a schedule will be developed for each resident with showers according to resident preference. On 3/2/20 at 10:07 a.m., during an observation, Resident #115 was in his room, in bed. Resident #115 was unshaven, and his fingernails were long extending 1/2 inch past his fingertips. There was a brown and black substance under some of the nail beds. Resident #115 said, I don't like my nails like this, but they don't do anything for me. Today was the first day I got a shower, and I have been here 2 weeks. No one comes to help me when I need it. On 3/3/20 at 8:40 a.m., the medical record revealed Resident #115 was admitted to the facility on [DATE]. The record included a Certified Nursing Assistant (CNA) Kardex (a document that provides important information on resident care) documented the residents bathing routine preference was shower on the evening shift on Tuesday, Thursday and Saturday. The care plan documented Resident #115 preferred to receive showers on the evening shift on Tuesday, Thursday and Saturday. The goal for Resident #115 specified, residents' preferences will be honored. The CNA Plan of Care Response History documented Resident #115 received a shower on 2/27/20 and 2/29/20. Resident #115 received a total of 2 showers during his stay at the facility 2/13/20 through 3/2/20. The medical record contained no documentation Resident #115 had refused showers or was too ill to take a shower. On 3/3/20 at 3:26 p.m., in an interview the Unit Manager said the resident was not feeling well when he first arrived at the facility, so he received bed baths. The B Wing Unit Manager confirmed there was no documentation of bed baths for Resident #115.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** Based on observation, interviews, and policy review the facility failed to ensure 1 (Resident #46) of 2 residents observed during two-person transfer assistance. The facility failed to ensure Resident #46 was free of accidental hazards and received adequate supervision to prevent accidents. The findings included: Review of the facility's Standards and Guidelines: SG Mechanical Lifts, Section #5. When using the mechanical lift, 2 staff members should assist with the procedure to ensure resident and staff safety. Resident #46 was observed on 3/3/20 at 4:08 p.m., being transferred from the wheelchair to the bed. Certified Nursing Assistant (CNA) Staff L was observed transferring Resident #46 using a Hoyer Lift without assistance. On 3/3/20 at 4:10 p.m. during an interview CNA Staff L confirmed she was to have two staff for a Hoyer lift transfer. On 3/3/20 at 4:30 p.m., during an interview the Regional Consultant said the Hoyer lift transfers are a two-person assist transfer.
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, review of facility policy, resident and staff interviews, the facility failed to have a system to maintain Continuous Positive Pressure ([MEDICAL CONDITION]) machines in a sanitary manner for 2 (Resident #99 and #370) of 3 residents who use a [MEDICAL CONDITION] machine (helps you breathe more easily while you sleep). The facility failed to provide oxygen as ordered by the physician for 1 (Resident #369) of 1 resident sampled for respiratory care. The findings included: The facility policy North Florida Medical [MEDICAL CONDITION]/Bi-level Review specified the [MEDICAL CONDITION]

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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LEHIGH ACRES HEALTH AND REHABILITATION CENTER	**1550 LEE BOULEVARD LEHIGH ACRES, FL 33936**

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F 0695 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) machine could be wiped clean with a damp cloth. The facility policy 12.07.16.018, Standards and Guidelines Oxygen Administration (revised 11/1/16) specified, verify that there is a physician's order for the oxygen and review the physician's order for oxygen administration. 1. On 3/2/20 at 11:08 a.m., during an observation, Resident #99 had a [MEDICAL CONDITION] machine on his nightstand. The [MEDICAL CONDITION] machine was dirty and had a layer of dust and debris surrounding the site of the connection tubing and debris on top of the machine. A review of the medical record documented Resident #99 had a [DIAGNOSES REDACTED]. A physician order dated [DATE] documented Check [MEDICAL CONDITION] sterile water is filled every shift and date when opening new water. Cleanse [MEDICAL CONDITION] mask daily with soap and water, air dry. Change [MEDICAL CONDITION] tubing weekly Wednesday evening shift. 2. On 3/2/20 at 12:09 p.m., during an observation Resident #370 had a [MEDICAL CONDITION] machine on his nightstand. The [MEDICAL CONDITION] machine had a thick layer of dust surrounding the settings dial and at the site of the connection tubing site. The [MEDICAL CONDITION] machine had debris and stains on top of the machine. Resident #370 said the nurse puts water in it for him. Resident #370 said no one cleans it, I did it when I was home, but I can't do it here. A review of the medical record revealed Resident #370 had a [DIAGNOSES REDACTED]. Check [MEDICAL CONDITION] sterile water in the evening shift, change [MEDICAL CONDITION] filter and clean [MEDICAL CONDITION] machine. On 3/4/20 at 8:55 a.m., Licensed Practical Nurse (LPN) Staff I confirmed Resident #99 [MEDICAL CONDITION] machine was dirty and said she would wipe it with an antibacterial wipe. The Staff I said the machine belongs to the facility and it should have been cleaned daily. The LPN confirmed Resident #99 was not able to apply or maintain the [MEDICAL CONDITION] machine independently. On 3/4/20 10:35 a.m., in an interview, Resident #370 said, I have asked the aides before to help me with the [MEDICAL CONDITION] machine, but they were not able because a nurse had to do it. Resident #370 said I know the [MEDICAL CONDITION] machine is dirty, it is filthy, but I can't clean it. On 3/4/20 at 10:37 a.m., Registered Nurse Staff K confirmed the [MEDICAL CONDITION] machine belonging to Resident #370 was dirty. Staff K said she did not know who was responsible to clean the [MEDICAL CONDITION] machine. On 3/4/20 at 12:14 p.m., in an interview the Unit Manager verified there was a physician order for [REDACTED]. 3. A review of the medical record for Resident #369, contained a physician order dated [DATE] for oxygen at 2 LPM via nasal cannula continuously and as needed. On 3/2/20 at 9:25 a.m., during an observation Resident #369 was in bed with oxygen on via a nasal cannula through an oxygen concentrator. The setting for the oxygen was a 1 Liter Per Minute (LPM). On 3/3/20 at 8:34 a.m., Resident #369 was observed in her bed with the oxygen concentrator on and nasal cannula in place. The oxygen concentrator was set at 1 LPM. On 3/4/20 at 8:11 a.m., Resident #369 was in bed and the oxygen was turned off. On 3/4/20 at 8:41 a.m., in an interview Registered Nurse Staff K, she said, the oxygen order for Resident #369 was as needed at 2 LPM. The RN confirmed the observation via photographic evidence the oxygen was set at 1 LPM on 3/2/20 and 3/3/20. A review of the facility Treatment Administration Record (TAR) for Resident #369 specified the resident was to receive oxygen at 2 LPM via nasal cannula every shift. The TAR had documentation the nurse had signed that the oxygen was administered as ordered on the day, evening and night shift on 3/1/20, 3/2/20 and 3/3/20. Photographic evidence obtained