STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105495	A. BUILDING _____ B. WING _____	**08/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HILLCREST HEALTH CARE AND REHABILITATION CENTER	**4200 WASHINGTON ST HOLLYWOOD, FL 33021**

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 interviews, and record review the facility failed to answer the call lights in a timely manner, resulting in facility failing to provide professional standards of practice for needed personal care for 3 out of 3 sampled residents (Resident #1, #2 and #4). Findings included: 1. During a telephone interview, conducted on 08/14/20 with Resident #1's family member, she reported that the resident was at the facility from 07/23/20 to 08/05/20. While in the facility, Resident #1 informed the family member that the staff would take hours to come and assist him when needed. He once used the call light for help and had to wait 4 hours for someone to come into the room and help him change. He was always complaining about the time it took nursing staff to come into his room every time he needed care. Many times, he was left wet for hours and he would call his family from the facility to let them know. The staff was aware of Resident #1's concerns, however, nothing changed. The resident's family member further reported that they decided to take him home because of lack of care by staff at the facility. Record review of the admission Minimum Data Set, (MDS) for Resident #1 showed that his Brief Interview of Mental Status, (BIMS) score was 15, which is cognitive intact. Further review of care plan dated 07/26/20 showed that he requires incontinence management and requires assistance with Activity of Daily Living, (ADL's), transfers, and safety management. Review of progress notes dated 07/24/20 revealed that the writer wrote: family called facility stating resident stated he was wet during conversation. 2. In an interview conducted on 08/17/20 at 9:00 AM, with Resident #2, she reported that it has been very difficult to be isolated in the room for days. When asked about the call light response by staff, she reported that the afternoons and night times are not great. She further reported that her roommate, Resident #3 is nonverbal, and needs help going to the bathroom. Lastnight staff left her in the bathroom for two hours and did not come into the room to assist her back in bed. When Resident #3 pulled the call light in the bathroom, she was yelled at for doing so. Resident #2 stated that staff is not happy when you use the call light too many times, and they will come into the room to tell you to stop but won't help. Resident #2 added that they will eventually help but it may take hours. Record review of Resident #2's MDS dated [DATE] showed a BIMS score of 13, which is cognitively intact. Record review of Resident #3 showed that she is non-verbal and can make herself understood with facial gestures. Review of the MDS dated [DATE] revealed that she is occasionally incontinent of bladder and bowel. A care plan dated 06/04/20 documented that Resident #3, has altered bladder elimination and altered bowel elimination. 3. In an interview with Resident #4, conducted on 08/17/20 at 9:40 AM, she reported that when she was in the positive COVID-19 unit,when she was admitted back from the hospital on [DATE], it took hours for anyone to come into her room when she used the call lights. According to the resident the staff only came into the room [ROOM NUMBER] times a day, and she would not see anyone at night. Record review of the MDS dated [DATE] revealed a BIMS score of 15, which is cognitively intact. It further revealed that she was transferred to the hospital on [DATE] and readmitted back on 07/23/20. In an interview conducted on 08/17/20 at 3:25 PM, with the facility's Director of Nursing, she acknowledged all findings.
F 0790 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide routine and 24-hour emergency dental care for each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide dental services in a timely manner for 1 of 1 sampled residents reviewed for dental care (Resident #3). The findings included: In an interview conducted with Resident #2, on 08/17/20 at 9:00 AM, she reported that her roommate, pointing at bed 2, (Resident #3) has been complaining of tooth pain for days and it was not addressed by the facility. At that time, when Resident #3 was asked by the surveyor if she has tooth pain, she nodded with her head yes. She also made a painful facial gesture, indicating pain. Record review of Resident #2's MDS (Minimum Data Set) assessment dated [DATE] documented a Brief Interview of Mental Status, (BIMS) score of 13, which is cognitively intact. Record review of Resident #3 revealed that she is non-verbal and can make herself understood with facial gestures. Continued record review of Resident #3's care plan dated 06/04/2020, revealed that she had missing teeth and a loose tooth revised on 04/10/20. An intervention was noted in place to coordinate an arrangement for dental care and transportation as needed or ordered. Review of the Telemedicine visit dated 07/09/20 revealed that Resident #3 is with right upper loose tooth and to consult the dentist for tooth pain. Progress note dated 08/11/20 revealed that Resident #3 needs a consultation for the dentist for tooth pain. Review of the physician's orders [REDACTED]. In an interview conducted on 08/17/20 at 12:30 PM, Staff D, a Registered Nurse, reported that Resident #3 is non-verbal but can make herself understood. She further reported that Resident #3 was given Tylenol today for tooth pain. When asked by surveyor as to how she knew that Resident #3 was in pain, she reported that Resident #3 made a painful facial gesture and pointed at her teeth. Upon interview, conducted on 08/17/20 at 12:42 PM, Staff E, the Charge Nurse, she reported that when an order is written for a dental consultation, it is scanned and placed in a binder at the nurse's station. She further reported that the Social Worker or the Resident Assistant (Staff G), checks the binder daily and will make the appointments as necessary. When asked if the dentist has been called to the facility in the past few months she said yes. She further stated that if some residents have a dental emergency or dental pain, they will contact the dental office. In an interview conducted on 08/17/20 at 3:20 PM, with the Director of Nursing, she stated: It must have been a miscommunication with the staff who ordered the consultation for the dentist. She further confirmed the Social Worker or Staff G, is in charge of checking the daily consultation binder and making the appointments as needed. During a further interview, she further acknowledged all of the findings. During a follow up interview conducted on 08/27/20 at 3:30 PM, Staff G reported that she checks the appointment binder daily for any appointments that needs to be made. She further explained that the doctor's nurses or the nurse practitioner, will place a copy of the orders, in the binder and she checks it daily. She will then fax the face sheet to the doctors office(s) for any appointments. Staff G reported that any dental appointments are usually made using the in- house dental company. When asked as to why the appointment was not made for Resident #3 for the dental consultation, she reported that she has been confined to the COVID-19 positive wing and is not able to go into other areas of the facility. She further commented that someone else will need to take care of the appointments. Staff G further stated that at times, the DON walks towards the positive COVID-19 unit and provides her with the appointment binder at the threshold of the unit.
F 0806 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.** Based on observation, interview, and record review the facility failed to provide food items that accommodate preferences

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 0806 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) for 3 out of 3 sampled residents (Resident #3, #5 and #4). Findings included: 1. In an observation conducted on 08/17/20 at 9:25 AM, it was noted that Resident #3's breakfast tray was brought into the room. Closer observation revealed that the meal ticket was for a Regular No Added Salt (NAS) diet, with 2 Hard Boiled Eggs, yogurt and Sausage Patty. However, the breakfast plate on the tray did not include the Sausage Patty. In an interview conducted on 08/17/20 at 9:27 AM, Staff F, Certified Nurse Assistant, she was asked as to why the Sausage Patty was not on the tray. She stated, Maybe they are out of it. Record review of Resident #3 revealed that she is non-verbal with Brief Interview of Mental Status (BIMS) score of 10, which is moderately impaired. 2. In an observation conducted on 08/17/20 at 9:35 AM, it was noted that Resident #5's breakfast tray was brought into the room. Closer observation revealed that the meal ticket was for Regular diet with French Toast and Sausage Patty. The Breakfast tray consisted of French toast but did not have the Sausage Patty. During the observation, the resident was unable to communicate with the surveyor. 3. In an interview conducted on 08/17/20 at 9:40 AM, with Resident #4, she reported that the facility is always making a mistake with the meal trays. She further stated that they are always out of fresh fruits and bananas which is some of her food preferences. Record review of Resident #4 revealed that she has a Brief Interview of Mental Status (BIMS) score of 15, which is intact cognitive response. 4. In an interview conducted on 08/17/20 at 9:50 AM, with Resident #6, he reported that before the COVID-19 pandemic, dietary staff would provide the menus for the week, the Friday before. He explained that you make your selections, and staff would pick it up the same day or the day after. Since the COVID-19 situation, the residents are provided with the menu choices for that day of the week. He further reported that at times he does not like the food that is provided, and he has to call the kitchen for alternates. In an interview conducted on 08/17/20 at 12:00 PM, with the facility's Clinical Dietitian, she reported that the residents are provided with the standard menu for the week and all preferences are taken from the admission assessment. The Clinical Dietitian further reported that the facility has not run out of sausage patties and fresh fruit. She acknowledged all of the findings.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to implement the infection prevention and control plan, as evidenced by failing to follow infection control practices related to isolation as well as donning and doffing in the COVID-19-PUI (Person Under Investigation Unit) unit for 17 out of 17 residents. Facility also failed to follow CDC guidelines for designated COVID-19 PUI unit. The findings included: Review of the facility's policy titled COVID-19-Pandemic Plan, revised on 08/04/20 documented that transmission-based precautions are based on Center for Disease Control (CDC) guidelines. Review of the CDC guidelines titled Identify Space in the Facility that Could be Dedicated to Monitor and Care for Residents with COVID-19, updated June 25, 2020 revealed that facilities need to create a plan for managing new admissions and readmission whose COVID-19 status is unknown. It further stated that the Health Care Professional (HCP), While awaiting results of testing, HCP should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown when caring for these residents Further review of the CDC titled Create a Plan for Managing New Admissions and Readmissions Whose COVID-19 Status is Unknown, updated June 25, 2020, showed that HCP should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a face shield that covers the front and sides of the face), gloves, and gown when caring for these residents. Record review of the facility's list of residents in the PUI unit, showed that 12 residents were placed in this unit because of admission/readmission, 3 residents were placed in the unit because they are on [MEDICAL TREATMENT] and 2 residents were placed in the unit because they had positive COVID-19 roommates. In an interview conducted on 08/17/20 at 9:10 AM, with the Director of Nursing, she reported that they have a unit with suspected residents who were exposed but currently with no symptoms. According to her, this unit is near the COVID-19 positive unit. When asked what type of residents are in this unit, she reported that it is a mixture of residents. She further stated that some of the residents are new admission, readmission, and roommates of positive COVID-19 residents. In an observation conducted on 08/17/20 at 9:44 AM, Staff A, Wound Care Specialist, was observed coming out of the Person Under Investigation (PUI) unit, wearing a gown, face mask, gloves and a face shield. Closer observation showed that she had an N95 mask underneath the surgical mask. In this observation Staff A came out of the PUI unit into the East unit which is not part of any isolation units. Staff A was asked as to why she did not dispose of her PPE after coming out of the PUI unit she stated, I am the wound care specialist and I am not working for this facility. She further reported that she saw some residents in the PUI unit, and that she wanted to dispose of her gown and other PPE but could not find a garbage bin to throw the PPE away. According to Staff A, this facility does not have a clear section or an empty room for Donning and Doffing properly like other facilities. The surveyor expressed concerns of coming out of the PUI unit after treating and managing residents with pressure ulcers and not disposing of the PPE appropriately. She (Staff A) then walked back into the PUI unit and disposed of her face-shield and gown in a regular garbage bin outside of the rooms. Staff A proceeded to walk outside the unit with the same surgical mask on top of her N95 mask. In an interview conducted on 08/17/20 at 12:20 PM, with Staff B, Registered Nurse, she reported that in the PUI unit, the hallways are considered clean and the rooms are considered dirty. She further explained that donning is done before going into resident's rooms and doffing is done before leaving residents' rooms. She further stated that she is not able to clean her face-shield after leaving residents' rooms because there is no Germicidal Bleach Wipes around the unit. In this interview, the surveyor looked around the unit with Staff B, and could not locate any Germicidal Bleach Wipes. Staff B reported that there are no close lid garbage bins in the rooms for staff to dispose of PPE before leaving the rooms. She then proceeded to show surveyor room [ROOM NUMBER] which is on contact/droplet isolation that did not have an appropriate garbage bin with a close lid. In another observation conduced on 08/17/20 at 12:40 PM, Staff C, Physical Therapist Assistant (PTA), was observed coming out of room [ROOM NUMBER] (isolation room) in the PUI unit. Further observation revealed that he left the isolation room, with the full PPE and a walker that was used for therapy in his hands. Closer observation showed that he had an N95 mask, goggles, face shield, gown and gloves on while exiting the room. He then proceeded to walk into another isolation room with the same PPE and gloves. He did not change his gloves and perform hand hygiene and disinfect the walker before walking into another isolation room. In an interview conducted with Staff C, on 08/17/20 at 12:50 PM, he reported that he is new in this facility and only started last week. He stated that he is used to working with patients in Positive COVID-19 units and was told to use two gowns and two gloves before going into the rooms. He further asked the surveyor if he was in a PUI unit or the positive COVID-19 unit since the facility has another unit that is for positive COIVD-19 residents. Staff C also stated that on the Positive COVID-19 units, he always has the PPE gear, and he disposes of it when he is ready to leave the unit. When asked as to what the protocol in the PUI unit is, he did not know. In an interview conducted on 08/17/20 at 1:30 PM, the Director of Nursing reported that in the PUI unit, the hallways are considered cleaned and the rooms that are on isolation they consider dirty. She further stated that staff needs to gown up before going into the rooms and perform doffing before leaving the rooms. In an interview conducted on 08/17/20 with the facility's Corporate Nurse, she reported that when the Department of Health was in the facility last week, they recommended to treat the PUI unit like they do in the Positive COVID-19 unit. When asked to elaborate on what it means to treat the PUI unit like the positive COVID-19 unit, she did know. She further acknowledged that the facility's staff is not following their own policy and CDC guidelines in the PUI unit that is treated as such: The hallway is clean, and the rooms are dirty. The Corporate Nurse also reported that she needs to contact the Health Department for clarification on the above recommendation.