STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105519	A. BUILDING _____ B. WING _____	**06/24/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NSPIRE HEALTHCARE PLANTATION	**6931 W SUNRISE BLVD PLANTATION, FL 33313**

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 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 and interview, the facility failed to develop a plan of care that addressed all wounds; and implement a care plan for 1 of 3 sampled residents reviewed for pressure ulcers (Resident #1). The findings included: Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of Resident #1's records revealed a Comprehensive Assessment, dated 03/24/20, that documented Resident #1 had severe cognitive impairment, and required total assistance of two persons with activities of daily living, had one unstageable deep tissue injury (DTI), and was receiving hospice services. Resident #1 was care planned on 09/17/19 for an excoriated sacrum related to immobility. An intervention on this care plan included weekly treatment documentation to include measurements of each area of skin breakdowns with length, depth, type of tissue and exudate. Resident #1 had a care plan, dated 01/14/20, for the potential for pressure ulcer development related to immobility, stroke, diabetes, and terminal illness. Resident #1's care plans, dated 04/15/20, for a pressure ulcer to the right lateral foot, a pressure ulcer to the left lateral foot, and a pressure ulcer medial foot (which foot not specified). Interventions included: to administer treatment as ordered and monitor for effectiveness, and weekly treatment documentation to include measurement of each area of skin breakdown with, length, depth, type of tissue and exudate. A review of Resident #1's physicians order revealed an order dated 11/18/19 for Skin observation assessment every day shift every Friday. A review of Resident #1's treatment administration record revealed documentation of a skin observation done every 'day' shift on Friday. A review of Resident #1's record did not reveal a weekly skin observation of the resident's wounds condition with measurements and/or stages. A review of the skin observation tool dated 04/24/20 at 4:03 PM, documented sacrum pressure ulcer, and blister. The Notes section documented: old wound with dressing as per order, open blister under left great toe. The length, width, depth and stage of the wound were blank A review of the skin observation tool dated 05/12/20 at 11: 42 AM for site, type, length, width, depth and stage were blank. The Notes section documented: no new skin issues noted, treatment in place for bilateral feet. The Skin observation tool, dated 05/13/20 at 3:33 PM, documented: Site - sacrum, type - pressure, stage-4. The length, width, and depth had no documentation. The Notes section documented the resident as a hospice patient. The resident is diagnosed with [REDACTED]. The Skin observation tool, dated 05/20/20 at 3:33 PM, revealed the site, type, length, width, depth, and stage were blank. The Notes section documented: no new skin issues noted, treatment in place for current wounds. The Skin observation tool, dated 05/27/20 at 9:33 AM, revealed the site, type, length, width, depth, and stage were blank. The Notes section documented no new skin issues noted. The Skin observation tool, dated 06/03/20 at 9:33 AM, revealed the site, type, length, width, depth, and stage were blank. The Notes section document it no new skin issues noted. A review of the VOHRA Wound Physician's wound care telemedicine follow up evaluation, dated 06/30/20, documented the chief complaint for this patient as multiple wounds. The follow up evaluation documented Resident #1 had 9 wounds that were being treated, including the three wounds on the care plan (left lateral foot, left medial foot, and right lateral foot). The evaluation documented an unstageable wound due to necrosis of the left first toe, stage 1 pressure wound of the right medial foot, unstageable due to necrosis of the sacrum, stage 2 pressure wound of the right heel blister, and an unstageable due to necrosis of the right lateral foot. There were no care plans for Resident #1's sacral pressure ulcer, left first toe pressure ulcer, right medial foot pressure ulcer, right heel pressure ulcer, and right lateral foot. An interview was conducted with Staff A, a licensed practical nurse (LPN), on 06/22/20 at 2:45 PM. Staff A stated she used to be the wound care nurse and had provided care for all wounds on first and second floor. Staff A stated she left the facility around the end of March (03/20). Staff A stated she just came back to work last week and was no longer wound care nurse. Staff A stated that the weekly wound notes were done by the wound care nurse with wound care doctor; and skin checks were done by the primary nurse using the skin observation tool. Staff A stated she doesn't know how it's been since March. Staff A stated she remembered Residence #1 was here for quite some time; and had excoriation to the resident's bottom that would come and go. Staff A recalled a left lateral foot DTI. Staff A stated when the resident came in, he first came into the first floor. The resident's family member would visit and check the resident from head to toe. Staff A stated she did recall the resident declining and had to be placed back on tube feedings. An interview was conducted with Staff B, minimum data set (MDS) coordinator, on 06/22/20 at 3:00 PM. The MDS coordinator stated that on the quarterly assessment dated [DATE], Resident #1 had one DTI. MDS stated it was on one foot. The MDS stated she gets her information by checking the medication and treatment reports, wound reports, wound care nurse, and unit manager. He was scheduled for another quarterly prior to him leaving the facility.
F 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide the correct treatment and services ordered to potentially promote healing, prevent infection and prevent new ulcers from developing for 1 of 3 sampled residents reviewed for pressure ulcers (Resident #1). The findings included: Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of Resident #1's records revealed a Comprehensive assessment dated [DATE] that documented Resident #1 had severe cognitive impairment and required total assistance of two persons with activities of daily living, had one unstageable deep tissue injury (DTI), and was receiving hospice services. The facility documented the resident had a decline in oral intake. A review of Resident #1's care plan revealed a care plan for being at risk for further alteration in skin integrity related to decreased mobility, incontinence, diabetes, and stroke, dated 06/14/18. A review of Resident #1's care plan, dated 09/17/19, documented the resident has an excoriated sacrum related to immobility. Interventions included: weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate, administer treatments as ordered and monitor for effectiveness, and the resident required supplemental protein, amino acids, vitamins, minerals as order to promote wound healing. Resident #1 was further care planned for the potential for pressure ulcer development related to immobility, stroke, diabetes, and terminal illness, dated 01/14/20. Resident #1 had a care plan, dated 04/15/20, for a pressure ulcer to the right lateral foot, a pressure ulcer to the left lateral foot, and a pressure ulcer medial foot (which foot not specified). Interventions included: administer treatment as ordered and monitor for effectiveness, assess / record / monitor wound healing measure length, width, and depth where possible, assess and document status of wound parameter, wound bed and healing progress, report improvements and declines to the doctor, monitor / document / report as needed any changes in skin status: appearance, color, wound healing, signs and symptoms of infection, wound size, stage, weekly treatment documentation to include measurement of each area of skin breakdown with, length, depth, type of tissue and exudate. A review of Resident #1's physicians orders revealed the following: 11/18/19: Skin observation assessment every day shift every Friday. 04/15/24: Zinc sulfate tablet 220 mg (milligrams) one tablet by feeding tube one time a day for wound healing. 05/04/20: Wound care

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 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) TheraHoney (debridement solution), apply to left lateral heel topically every day shift every Monday, Wednesday, Friday. Cleanse wound with normal saline, apply TheraHoney, and apply foam silicone border. 05/04/20: TheraHoney, apply to left medial foot topically every day shift every Wednesday and Friday. Cleanse wound with normal saline, apply TheraHoney, and apply foam silicone border. 05/04/20: TheraHoney, apply to right lateral heel topically every day shift every Monday and Friday. Cleanse wound with normal saline, apply TheraHoney, and apply foam silicone border. 05/13/20: Wound care consult for sacral wound. 05/13/20: TheraHoney, apply to sacrum topically every day shift every Monday Wednesday Friday. A review of Resident #1's treatment administration record (TAR) documented a skin observation assessment was completed every 'day' shift on Friday. The TAR further documented wound care using TheraHoney to the left lateral heel every 'day' shift every Monday Wednesday and Friday starting on 05/06/20. Resident #1's TAR further documented wound care using TheraHoney to the left medial foot every 'day' shift every Wednesday and Friday, started 05/06/20 The TAR further documented wound care using TheraHoney to the right lateral heal every 'day' shift every Monday and Friday, started on 05/08/20. The TAR further documented wound care using TheraHoney to the sacrum every Monday Wednesday and Friday, started on 05/15/20. A review of the VOHRA Wound Physicians Wound care telemedicine follow up evaluation, dated 06/03/20, documented the chief complaint for this patient was multiple wounds. The wounds were documented as follows: (a) Focused wound exam, site 1, documented unstageable DTI of the right lateral heel intact skin. Wound progress no change. Dressing treatment plan primary dressing [MEDICATION NAME] apply once daily for 30 days (b) Focused wound exam, site 3, documented stage 4 pressure wound of the left medial foot, wound progress deteriorated. Dressing treatment plan primary dressing [MEDICATION NAME] apply once daily for 30 days, Alginate calcium apply once daily for 30 days. Reason for no debridement was telemedicine. (c) Focused wound exam, site 4, documented unstageable due to necrosis of the left lateral foot. Wound progress deteriorated dressing treatment plan primary dressing [MEDICATION NAME] apply once daily for 30 days (d) Focused wound exam, site 5, unstageable due to necrosis of the left first toe. Wound progress deteriorated dressing treatment plan [MEDICATION NAME] apply once daily for 30 days. Reason for no debridement telemedicine. (e) Focused wound exam, site 6, stage one pressure wound of the right medial foot. Wound progress no change. Additional wound detail unable to visualize this wound. Primary treatment plan [MEDICATION NAME] apply once daily for 30 days. (f) Focused wound exam, site 7, unstageable due to necrosis sacrum. Wound progress deteriorated. Dressing treatment plan Santyl apply once daily for 30 days; zero phone sterile gauze supplies once daily for 30 days dry protective dressing apply once daily for 30 days. Reason for no debridement telemedicine. (g) Focused wound exam, site 8, stage to pressure wound of the right heel blister dry primary dressing [MEDICATION NAME] apply once daily for 30 days dry protective dressing apply once daily for 30 days (h) Focused wound exam, site 9, unstageable due to necrosis of the right lateral foot primary dressing Santyl apply once daily for 30 days, xeroform sterile gauze apply once daily for 30 days and a dry protective dressing apply once daily for 30 days. Reason for no debridement telemedicine. The summarized wound care assessment and individualized treatment plan documented: Site 1 dressing treatment plan continue [MEDICATION NAME] once daily. Site 3 Full thickness wound optimized for autolytic debridement by using the below treatment plan. Dressing treatment plan add [MEDICATION NAME] once Daily and Alginate calcium, discontinue leptospermum honey. Site 4 Full thickness wound optimized for auto autolytic debridement by using the below treatment. Dressing treatment plan continue [MEDICATION NAME] once daily to dry protective dressing. Site 5 Full thickness wound optimized for auto autolytic debridement by using the below treatment plan. Dressing treatment plan continue [MEDICATION NAME] once daily. Site 6 dressing treatment plan continue [MEDICATION NAME] once daily. Site 7 full thickness wound optimized for auto autolytic debridement by using the below treatment plan. Dressing treatment plan to add Santyl once daily and xeroform sterile gauze once daily discontinue zinc ointment. Site 8 dressing treatment plan to continue [MEDICATION NAME] once daily. Dry protective dressing. (initial evaluation) Site 9 full thickness wound optimized for auto autolytic debridement by using the below treatment plan. Santyl daily, xeroform sterile gauze daily. (initial evaluation) Follow up evaluation by wound care specialist within seven days with further intervention as indicated. A review of Resident #1's progress notes revealed documented: 05/04/20 at 10:08 AM: Wound care provided, dry dressing applied. Patient tolerated well. Will continue to monitor. 05/04/20 at 1:48 PM: Resident was seen by wound care doctor telemedicine on 04/23/20, unstageable deep tissue injury (DTI) to right lateral heel 2.5 x 3.3 cm, unstageable wound to left lateral heel due to necrosis 2.5 x 3.1 cm, Stage 4 wound to left medial foot. Orders received and noted. Plan of care discussed with spouse. 05/13/20 at 3:41 PM: Resident hospice patient. Resident is diagnosed with [REDACTED]. 05/13/20 at 4:26 PM: late entry documented hospice doctor made aware, order received and noted. Wife informed of change in status and treatment. On 05/29/20, Resident #1 was diagnosed with [REDACTED]. A progress note dated 06/04/20 at 4:00 PM for a change of condition documented: Resident received in bed labored breathing noted. Oxygen 2 L nasal cannula with oxygen saturation 96%. Hospice, MD (physician), and wife made aware. Orders received to transfer resident to emergency room for further evaluation. Blood pressure 95/48, pulse 110, respirations 32, temperature 100.3 axillary. Safety measures maintained. A physician order [REDACTED].#1 to transfer to the emergency roiagnom on [DATE] for respiratory distress / failure to thrive. A telephone interview was conducted with the family member of Resident #1 on 06/23/20 at 12:00 PM. The family member stated she would visit the resident daily and would assist with care. The family member further stated the resident had a blister on his backside and on his left toe. The blister had opened, and the facility was treating the wound. The family member stated after visitation was suspended due to the coronavirus, she would call to check on the resident daily. She would speak with the wound care nurse and get updates. After a while, she was called by another nurse who informed her the resident had a pressure ulcer on his buttocks and they were addressing it. The family member stated she was not informed of the wounds to both the resident's legs/feet. The family member stated she was informed of the extent of the resident's wounds by the emergency room doctor. She stated they told her, he was septic from the sacral wound, and it needed surgery. A telephone interview was conducted with the Administrator on 06/24/20 for further documentation from the wound care physician, as the treatment orders for wound care that Resident #1 was receiving did not depict the treatment orders that the wound care physician documented the resident should have been receiving ([MEDICATION NAME]), and the wounds were deteriorating per the report on 06/03/20. The Administrator stated she would call the wound care doctor's office and see what she could find. As of 06/29/20, no further documentation was received from the facility.