STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105679	A. BUILDING _____ B. WING _____	09/14/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
REGENTS PARK OF SUNRISE	9711 W OAKLAND PARK BLVD SUNRISE, FL 33351

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 -** 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 interview and record review, the facility failed to conduct appropriate skin assessments for 1 of 3 sampled residents reviewed for wounds, Resident #1, as evidenced by inadequate documentation of an assessment of Resident #1's surgical incision resulting in the surgical incision becoming infected and dehisced, and failing to address a newly identified skin tear for Resident #1. The findings included: Review of the facility policy and definition of Neglect states in part, 'Failure to provide goods and/or services necessary to avoid physical harm, mental anguish or mental illness. Neglect may be a single act or several episodes of carelessness.' Review of the clinical record revealed Resident #1 was admitted to the facility for skilled nursing and skilled therapy services on 03/20/20 with pertinent [DIAGNOSES REDACTED]. Resident #1 resided on the B-unit. Review a MDS (Minimum Data Set) admission comprehensive assessment of Resident #1 dated 03/24/20 documents under Section C Cognitive Patterns, Resident has a Brief Interview for Mental Status (BIMS) rating of 2, indicating severe cognitive impairment. Review of Section M, Skin Conditions, documents Resident #1 has a surgical wound with the application of nonsurgical dressings (with or without topical medications). Review of a Care Plan dated initiated 03/21/20 documents 'Resident has actual wound surgical right hip. Goal - promote wound healing. Interventions - Treatment as ordered (refer to orders for current order). Observe that dressing is covering and adhering. Report loose dressing to nurse.' Review of the admission Physician Orders for Resident #1 dated 03/20/20, revealed no evidence of an order for [REDACTED]. Review of Resident #1's Medication Administration Orders (MAR) for March 2020 revealed no documentation of any assessment, monitoring or dressing changes conducted for Resident #1. Review of Resident #1's Treatment Administration Orders (TAR) for March 2020 revealed no documentation of any assessment, monitoring or dressing changes conducted for Resident #1. Review of the Nursing Progress Notes initial Nursing Assessment conducted by a Registered Nurse (RN) dated 03/20/20 at 7:40 PM, states in part under the category Skin Condition, 'Observation of skin integrity with routine care was provided during shift. Application of ointments/medication was provided during shift. Application of dressings (with or without topical medications) was provided. This is an existing skin condition. Care plan continues as it relates to skin.' There is no documentation in the Initial Nursing Assessment that indicates Resident #1 was admitted with a right hip surgical incision, the size of the incision or what the incision looked like. Review of a Nursing Progress by an RN dated 03/21/20 at 3:40 AM, revealed no documentation of an assessment of the right hip dressing or incision. Review of a Nursing Progress Note by a Licensed Practical Nurse (LPN) dated 03/21/20 at 11:40 AM, revealed no documentation of an assessment of the right hip dressing or incision. Review of a Skin Grid for All Other Skin Problems form, an RN documents on 03/21/20, no time documented, the site as 'Right Femur Fracture' length 3.5 centimeters (cm), width 0.1 cm, no drainage, wound bed pink, no odor, monitor site (glue).' Review of the clinical record, MAR and TAR for 03/21/20 revealed no documentation of any hip dressing removal, change or replacement provided to be able to document the length of the incision. Review of a Nursing Progress Note by an LPN dated 03/21/20 at 7:40 PM, documents 'non-removable dressing intact to right hip No signs/symptoms of bleeding noted.' Review of the Skilled Nursing Daily Note by a LPN dated 03/21/20 at 8:19 PM, reveals no documentation of an assessment of the right hip dressing or incision. Review of a Nursing Progress Notes by an LPN dated 03/22/20 at 2:04 AM, reveals no documentation of an assessment of the right hip dressing or incision. Review of the Skilled Nursing Daily Note by a LPN dated 03/22/20 at 2:11 AM, reveals no documentation of an assessment of the right hip dressing or incision. Review of the Skilled Nursing Daily Note dated 03/22/10 at 11:57 AM, documents 'Non-removable dressing intact to right hip. No signs/symptoms bleeding noted.' Review of a Nursing Progress Note by an LPN dated 03/22/20 at 6:04 PM, reveal no documentation of an assessment of the right hip dressing or incision. Review of the Skilled Nursing Daily Note dated 03/22/20 at 7:36 PM, documents 'Non-removable dressing intact to right hip. No signs/symptoms bleeding noted.' Review of the Skilled Nursing Daily Note dated 03/23/20 at 3:11 AM, reveals no documentation of an assessment of the right hip dressing or incision. Review of a Nursing Progress Note by an LPN dated 03/23/20 at 10:04 AM, reveals no documentation of an assessment of the right hip dressing or incision. Review of an Advanced Registered Nurse Practitioner (ANRP) Progress Note dated 03/23/20 documents the resident has a right hip surgical wound. There is no assessment of the incision or wound dressing documented. Review of a Skilled Nursing Daily Note dated 03/23/20 at 6:04 PM, reveals no documentation of an assessment of the right hip dressing or incision. Review of a Nursing Progress Note dated 03/24/20 at 12:43 PM by the RN, reveals no documentation of an assessment of the right hip dressing or incision. Review of a Skilled Nursing Daily Note dated 03/24/20 at 12:43 PM by the RN, reveals no documentation of an assessment of the right hip dressing or incision. Review of a Skilled Nursing Daily Note dated 03/24/20 at 1:57 PM, documents 'Right trochanter hip wound covered with brown surgical dressing, no drainage. Staples not present. No sign infection.' It is unclear how staples were determined not to be present when the observation was of a brown surgical dressing. Review of a Nursing Progress Note dated 03/25/20 at 1:20 PM by the LPN, documents 'Right hip dressing in place and no s/s (signs/symptoms) of infection noted. There are no staples or sutures present. No signs of infection. No drainage noted.' It is unclear how staples and sutures were determined not to be present when the observation was of a right hip dressing. Review of a Physician History and Physical note dated 03/25/20 documents the resident sustained [REDACTED]. The Physician documented under Skin: right hip surgical incision. There is no documentation of any assessment of the incision or surgical dressing. Review of a Nursing Progress Note dated 03/26/20 at 3:21 AM by the LPN, revealed no documentation of an assessment of the right hip dressing or incision. Review of a Skilled Nursing Daily Note dated 03/26/20 at 3:21 AM by the LPN, revealed no documentation of an assessment of the right hip dressing or incision. Review of a Nursing Progress Note dated 03/26/20 at 2:31 PM by the LPN, revealed no documentation of an assessment of the right hip dressing or incision. Review of a Skilled Nursing Daily Note dated 03/26/20 at 2:31 PM by the LPN, revealed no documentation of an assessment of the right hip dressing or incision. Review of the clinical record for 03/27/20 revealed no documentation of any Nursing Progress Notes or of Skilled Nursing Daily Notes for the day. Review of a Physician Geriatric Progress Note dated 03/27/20, documents the resident has a past medical history of [REDACTED]. Review of a Nursing Progress Note dated 03/28/20 at 1:33 AM by the LPN, revealed no documentation of an assessment of the right hip dressing or incision. Review of a Skilled Nursing Daily Note dated 03/28/20 at 1:33 AM by the LPN, revealed no documentation of an assessment of the right hip dressing or incision. Review of the clinical record for 03/29/20, revealed no documentation of any Nursing Progress Notes or Skilled Nursing Daily Notes for the day. Review of a Skilled Nursing Daily Note dated 03/30/20 at 1:58 PM by the LPN, documented 'Right trochanter hip surgical dressing in place no s/s infection noted. No sutures or staples present, no s/s of infection.' It is unclear how sutures and staples were determined not to be present when the observation was of a surgical dressing in place. Review of a Nursing Progress Note dated 03/30/20 at 1:58 PM, documents 'Surgical dressing in place, no s/s of infection noted. No staple or sutures present. No signs of infection. Continue to monitor.' It is unclear

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105679	A. BUILDING _____ B. WING _____	09/14/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
REGENTS PARK OF SUNRISE	9711 W OAKLAND PARK BLVD SUNRISE, FL 33351

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 -** Actual harm **Residents Affected -** Few	(continued... from page 1) how sutures and staples were determined not to be present when the observation was of a surgical dressing in place. Review of an ARNP note dated 03/30/20 documents the resident is status [REDACTED]. Review of a Skilled Nursing Daily Note dated 03/31/20 at 1:58 PM by the LPN, revealed no documentation of an assessment of the right hip dressing or incision. Review of a Nursing Progress Note dated 03/31/20 at 2:50 PM, documents 'During routine care residents surgical dressing is noted with drainage and foul odor. MD is informed and order is received for wound C & S (culture and sensitivity) to surgical site.' Review of a Skilled Nursing Daily Note dated 04/01/20 post event nursing note at 11:47 AM by the LPN documents 'Observation of skin integrity with routine care. Application of dressings (with or without topical medications). Will continue with plan of care.' There is no assessment of the right hip surgical incision that was noted draining and with a foul odor as documented on 03/31/20 at 2:50 PM. Review of a Physician Geriatric Progress Notes dated 04/01/20, the Physician documents under Chief Complaint: Surgical incision with moderate foul odor drainage. Patient complains of pain. Patient going to (Hospital A) for surgical incision evaluation. C & S done yesterday. Review of a Nursing Progress Note dated 04/01/20 at 11:47 AM by the LPN, documents 'Resident surgical site is noted with foul drainage. Recommendations send to (Hospital A) for evaluation of status [REDACTED]. site to right hip noted with drainage and foul odor. MD is informed and order send to ER (emergency room) at (Hospital A) for evaluation to right hip surgical site. Leave in stretcher.' Review of a Nursing Progress Note dated 04/01/20 at 12:35 PM by the LPN, documents 'Resident leave facility via transport going to (Hospital A) Medicated for pain.' Review of the MAR revealed on 04/01/20 at 10:08 AM, Resident #1 received Tylenol 650 milligrams for pain. Further, review of the MARs for March and April 2020, revealed Resident #1 was having a [MEDICATION NAME]-Menthol patch applied to the right hip daily for pain. In addition to the pain patch, Resident #1 was receiving [MEDICATION NAME] (pain medication) every 8 hours routinely for pain. Included with the nurse's initial who administered the medication, is a Pain Level indicating the level of pain on a scale from 1 to 10. Review of the documentation of pain from 03/21/20 through 04/01/20, revealed the [MEDICATION NAME] pain medication was administered 35 times on 35 shifts, and of those 35 doses, Resident #1 continued to complain of pain for 27 of the 35 doses administered, ranging from a level 2 to 8 out of 10. The LPN documented the resident's pain level for the 2:00 PM dose on 04/01/20 as an 8 out of 10. Review of the (Hospital A) Emergency Department (ED) records revealed Resident #1 arrived to (Hospital A) on 04/01/20 at 1:12 PM. Review of the ED History & Physical note completed by the ED physician on 04/01/20 states in part, 'Patient presented to the ED with chief complaint of right hip infection status [REDACTED]. Review of the results of a pelvic x-ray and lateral right hip x-ray completed on 04/01/20 at 2:30 PM documents in part, 'Abnormal gas is identified within the right hip soft tissue which may reflect soft tissue infection [DIAGNOSES REDACTED] (infection of the bone)/infection is not entirely excluded.' Review of the ED physician note dated 04/01/20 at 1:53 PM, documents under procedures - Consults - Nurse Practitioner with ortho and reviewed images (x-ray results). They are okay to discharge home with wet to dry dressings. Case discussed with Social Worker (SW) and has spoken with rehab facility and arranged wound care. Clinical Impression: [DIAGNOSES REDACTED].' Review of the hospital SW follow up note dated 04/01/20 at 3:34 PM documents 'SW placed call to (rehab facility) main line and discussed above with (Admissions Coordinator). Confirmed that patient is welcome to return today and will only need RN orders for wound care. (Admissions Coordinator) advised that her nursing staff will take care of it.' Review of a ED RN Progress Note dated 04/01/20 at 4:30 PM documents 'Patient and EMS verbalized understanding of discharge instructions.' Resident #1 was discharged from (Hospital A) ED on 04/01/20 at 4:35 PM with discharge instructions for 'Wound Check' with specific instructions in large bold capital letter print to 'PLEASE PERFORM WET TO DRY DRESSING CHANGES TO RIGHT HIP WOUND TWICE DAILY.' Review of a Nursing Progress Note dated 04/01/20 at 6:04 PM by the LPN, documents 'Resident is back from (Hospital A). Noted with a skin tear to left forearm that is covered with a gauze and secured with tape.' Review of the clinical record revealed no evidence of documentation Resident #1's physician was notified of the new development of a skin tear to the left forearm when the resident returned from the hospital. There is no evidence of any treatment ordered to address the newly identified skin tear to the left forearm. Further, there is no evidence of documentation the physician was notified of the ED and orthopedic wound care orders to include the wet to dry dressing changes to the right hip wound twice daily. Review of the clinical record revealed no right hip dressing changes were performed on 04/01/20 or 04/02/20. Review of the TAR revealed an order dated 04/02/20 at 6:03 PM for a dressing change to include 'Cleanse surgical site to right hip with normal saline solution, apply Medi-honey then cover with dry dressing daily every day shift.' The first right hip dressing is documented as performed on 04/03/20 on the day shift. There is no documentation of an order for [REDACTED]. The purpose of a wet to dry dressing is to draw the incision wound drainage out of the incision. Review of a Skilled Nursing Daily Note dated 04/01/20 at 7:35 PM by the LPN, documents 'Application of dressings (with or without topical medications) observation of skin integrity with routine wound care.' There is no documentation of an assessment of the surgical incision that had foul smelling drainage. Review of a Nursing Progress Note dated 04/01/20 at 7:35 PM by the LPN, documents 'Resident is observe on the floor on a left side lying position on the left of his bed MD is made aware and order is receive to send resident to (Hospital B) for evaluation due to fall .Resident leave the facility on a stretcher going to the hospital.' Review of a Skilled Nursing Daily Note dated 04/02/20 at 1:30 AM for the Readmission Return from Leave Data Collection, revealed no documentation of an assessment of the resident's right hip dressing or surgical incision or the assessment of the left forearm skin tear the resident returned with from Hospital A. Review of a Nursing Progress Note dated 04/02/20 at 1:08 PM documents 'Right trochanter surgical site. No staple or sutures present. No signs of infection.' There is no documentation of a dressing or if a dressing change was done. There is no documentation of an assessment of the left forearm skin tear. Review of a Nursing Progress Note dated 04/03/20 at 1:10 by the LPN, documents 'Right trochanter hip dressing change in place as ordered. There are no staple or sutures present. There are signs of infection that include odor. Resident has a skin/wound infection. Resident is receiving ABT (antibiotics).' There is no documentation of an assessment of the left forearm skin tear. Review of a Skilled Nursing Daily Note dated 04/03/20 at 1:10 by the LPN, documents 'Right trochanter hip dressing change in place as ordered. No sutures/staples present. Sign of infection -yes. Odor. Newly identified this shift. Contacted NP (nurse practitioner). Skin/wound infection. On po ABT (oral antibiotics).' There is no documentation of an assessment of the left forearm skin tear. Review of an ARNP Geriatric Progress Note dated 04/03/20, documents the resident has a right hip surgical incision with serosanguinous drainage. Under assessment: Right hip site infection. Start Keflex 250 milligrams (antibiotic) every 6 hours for 10 days. Review of the results of the wound culture that was obtained on 04/01/20 and available on 04/03/20, revealed the right hip incision wound was positive for a heavy growth of a bacteria called Providencia Stuartii. Review of a Nursing Progress Note dated 04/03/20 at 5:38 PM documents 'CNA (Certified Nursing Assistant) assigned to resident inform that resident is observe in lying position on floor with the head on the foot of the bed. Resident is transferred to bed via Hoyer lift and position to bed for comfort. Resident is in pain. Nurse Practitioner is made aware and order is received to send resident to (Hospital B) for evaluation due to fall.' Review of the Nursing Progress Notes from 03/20/20 through 04/03/20, revealed 4 Registered Nurses and 4 Licensed Practical Nurses, for a total of 8 licensed nurses, cared for Resident #1, all of whom failed to appropriately assess and monitor the resident's right hip surgical incision. On 09/10/20 at 12:45 PM an interview was conducted with LPN Staff 'A' working on the B Wing, and an inquiry made about surgical incision assessments. LPN Staff 'A' stated the incision dressing is assessed every shift and the dressing is changed normally once a day or per physician orders. An inquiry was made what would be done if the resident was admitted with no incision care orders to which she stated you would have to call the physician to see what he wanted done, stating some physicians like the incision open to air and some like a dressing on it. An inquiry was made if there would be any time a surgical incision dressing would be left on for 11 days to which she stated 'Absolutely not. You have to check the incision to make sure it is not getting infected for example redness, swelling, drainage or increased temperature around the area.' On 09/10/20 at 1:00 PM an interview was conducted with LPN Staff 'B' working on the C Wing and an inquiry made about surgical incision assessments. LPN Staff 'B' stated she would follow physician orders if he wanted it dressed or open to air. She stated you have to observe the incision dressing every shift and dressings are done daily. She stated if there are no physician orders you would call the surgeon or primary physician for dressing orders. An inquiry was made if it would be appropriate to leave a surgical dressing on for 11 days to which she stated, 'No, you have to look at the incision to make sure it is not getting infected, that is why you change the dressing daily.' On 09/10/20 at 3:36 PM, an interview was conducted with the Minimum Data Set (MDS) Coordinator and an inquiry made if they would update the care plan if a surgical incision infection was identified to which he stated he would have to check the care plans. He stated the following day after an event they discuss all new issues in the morning meeting and then update the care plan to reflect the changes. The MDS Coordinator proceeded to leave and returned 5 minutes later, however was unable to explain why the care plan was not updated to reflect the development of a surgical incision infection with the initiation of antibiotics or the newly identified left forearm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105679	A. BUILDING _____ B. WING _____	**09/14/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
REGENTS PARK OF SUNRISE	**9711 W OAKLAND PARK BLVD SUNRISE, FL 33351**

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 -** Actual harm **Residents Affected -** Few	(continued... from page 2) skin tear. On 09/10/20 at 3:45 PM an interview was conducted with the Director of Nurses (DON) and an inquiry made if it is their protocol to leave a surgical incision dressing in place for 11 days without changing it to which she stated the dressing would not be left in place for 11 days. An inquiry was made if there were no physician orders on admission for the care or assessment of a surgical incision, what is their process, to which she stated they would call the doctor for treatment orders. The DON was provided with the opportunity to review Resident #1's admission physician orders, MARs and TARs for March 2020 and she concurred there was no order of documentation of the surgical incision assessment or treatment. The DON then stated Resident #1's wound dehisced and the hardware was coming through and had to be replaced that is why they sent him out, then quickly stated it was a healing surgical site so there would be no point in assessing it. The DON was reminded Resident #1 had right hip surgery on 03/18/20 and was admitted to the facility on [DATE] so it was a fresh surgical incision, one that had not been appropriately assessed from 03/20 through 03/31 when it was discovered there was drainage and a foul odor seeping through the surgical incision dressing. The DON had no further comment. A request was made to the DON for the facility policy for surgical incision assessment and care. On 09/10/20 at 5:00 PM, before leaving the facility, the surgical incision assessment and care policy was not forthcoming. On 09/11/20 at 12:15 PM, the facility Administrator called stating they had additional information related to Resident #1 and would like to know what would be required. The Administrator was advised any additional information submitted will be reviewed. A request was made to the Administrator to also forward their policy for surgical incision care as that was not provided while onsite. The Administrator stated she will take care of it. On 09/14/20 at 2:02 PM, the clinical records from Hospital B for Resident #1 were received to include the resident's admission to the hospital on [DATE] post second fall. Review of a Discharge Summary note documented Resident #1 was admitted to the hospital post fall on 04/03/20 and discharged on [DATE]. The discharging physician documented 'The patient was admitted for pain in his right hip as well as a dehisced necrotic wound . He did develop some purulent drainage which was sent for cultures that showed Proteus Mirabilis as well as Morganella Morgani. He was seen by orthopedics who noted that his prosthesis is rotated on imaging and that there are gas bubbles concerning for deeper infection and possible impending infection of prosthesis and recommended the patient return to his original surgeon. The Discharge [DIAGNOSES REDACTED].' Resident #1 was discharged to Hospital A on 04/08/20, after a 5 day stay at Hospital B, to be followed by his original orthopedic surgeon and according to the DON's recollection, required surgery to replace the infected right hip hardware that was surgically implanted on 03/18/20. Review of the Center for Disease Control and Prevention (CDC) website revealed an article dated 05/09/19 related to surgical site infections (SSI) stating, 'A SSI is an infection that occurs after surgery in the part of the body where the surgery took place. Surgical site infections can sometimes be superficial infections involving the skin only. Other SSI are more serious and can involve tissues under the skin, organs or implanted material. Symptoms include redness and pain around the area where you had surgery; drainage of cloudy fluid from your surgical wound.' Review of the WebMD.com website, an Internet medical resource for nonmedical persons, with easy to understand language and explanations, was reviewed under How to Take Care of Your Wound After Surgery. The instructions included: 'When you're back home after your operation, make sure the cut made by your surgeon doesn't get infected. When do I take off the bandage? Your doctor will give you exact instructions on when and how to change it. Most wounds don't need one after a few days, but if you keep the area covered, it may help protect the cut from injury and it may heal faster. If you do keep a bandage on, change it every day. When should I call the doctor? Call if you see any signs that you're getting an infection around your wound. Some things to watch out for: pain that gets worse; redness or swelling; bleeding or oozing pus; increasing drainage from the wound; a bad smell.' As of 09/15/20 at 5:00 PM, no additional information was forthcoming from the facility and no policy for surgical incision care was provided.