STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106000	A. BUILDING _____ B. WING _____	**09/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
EVANS HEALTH CARE	**3735 EVANS AVE FORT MYERS, FL 33901**

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 record review, review of the facility's notification of change in condition policy, and staff interviews, it was determined the facility failed to provide timely care to a resident with a reported change in condition, for 1 (Resident # 892) of 2 sampled residents reviewed for hospitalization . The findings included: The facility policy N-105, Notification of Change in Condition (revised 9/21/2017) specified The Center to promptly notify the Patient/resident, the attending physician, and the Resident Representative when there is a change in the status or condition. The nurse will contact the physician. In the event that the attending physician does not respond in a reasonable amount of time, the medical Director may be contacted. If the Medical Director does not respond, call 911 and document in the medical record. Review of the care plan documented: Resident at high risk for Coronavirus disease (COVID-19) complications related to Cardiovascular disease, history of (H/O) [MEDICAL CONDITION]; The resident will be free from COVID 19 symptoms through the next review date; Monitor vital signs every shift and report abnormalities. Assess lungs sounds daily and as needed (PRN) or as directed per medical doctor (MD) orders, and report abnormalities. Assess oxygen saturation every shift and PRN or as directed per MD orders, and report abnormalities. The resident has a respiratory infection as evidence by a positive COVID-19 test; Assess lungs sounds daily and as needed (PRN) or as directed by medical doctor (MD) orders, and report abnormalities. Assess oxygen saturation every shift and PRN or as directed by MD orders, and report abnormalities. Encourage fluids to stay well hydrated. Record review revealed that Resident #892 had an ongoing situation of significant change and critical vital signs since 7/04/20. On 7/04/20 during the 7 to 3 shifts, the nurse documented Resident in bed refusing most diet and fluids, refusing medication, Temperature (T) 97.6, blood pressure (BP) 122/70, pulse (P)70 and respiration (RR) 20 doctor notified. On 7/04/20 at 3:45 p.m., the nurse documented On rounds noted patient with mild restlessness, extremities noted to be cold, toes & fingers with cyanosis. Temperature 96.8, heart rate 35 (normal resting heart rate is 60-100), and BP 77/54 (normal blood pressure is 120/80). Call out to MD services regarding findings. Patient noted to have Do- not- resuscitate (DNR) on record. Unable to obtain saturation reading, no shortness of breath (SOB) noted . nursing providing support and tender loving care (TLC). Director of Nursing (DON) made aware of patient status. On 7/04/20 at 4:00 p.m., the nurse documented Attempt to administer BP medication unsuccessful, no SOB or labored breathing noted. Attempt to administer by mouth (PO) fluids rejected. On 7/04/20 at 5:30 p.m., the nurse documented: Monitoring . patient awake+ alert refused routine med's + fluids, kept clean + dry. On 7/04/20 at 6:15 p.m., the nurse documented Temperature 97.8 unable to obtain BP or saturation no SOB or difficulty breathing noted. On 7/04/20 at 7:00 p.m., the nurse documented Extremities remain cold to touch digits + fingers cyanotic Heart Rate 48 unable to obtain BP Temp 97.0 continue to encourage fluid intake with no effect. On 7/04/20 at 8:00 p.m., the nurse documented Patient in bed with eyes closed respiration even + unlabored no immediate distress noted. On 7/4/20 at 9:00 p.m., the nurse documented Patient . at this time continued to be monitored, still unable to obtain B/P HR rate 50 no sob or respiratory distress noted. On 7/05/20 at 12:00 a.m., the nurse documented Patient with . . signs of respiration distress To encourage PO fluids with no results extremities remains cold with cyanosis. On 7/05/20 at 3 a.m., the nurse documented Patient with rest incontinent of bowel + bladder functions kept clean + dry condition unchanged. On 7/05/20 at 6:00 a.m., the nurse documented Patient condition unchanged. On 7/05/20 on the 3-11 shifts, the nurse documented Patient continued to refuse all PO intake extremities with increase coldness + cyanosis HR 50 unable to obtain BP or saturation. Extensive . oral care provided MD aware of decline. On 7/06/20 at 6:00 a.m., the nurse documented Condition remain guarded patient refused med's; food and fluids. Continue to provide activities of daily living (ADL) care + emotional support of TLC adequate oral care provided. Heart rate 48 unable to obtain BP or saturation Temperature 96.2. On 7/06/20 at 2:00 p.m., the nurse documented Resident in bed remain the same refused med's and fluid, safety measure in place, call light in within. On 7/07/20 at 5:45 a.m., the nurse documented Bilateral hands + feet with purple color, cold blanchable, eyes open halfway. Unresponsive to verbal. tactile stimuli. Unable to obtain B/P. Heart rate 56. Respirations shallow, even 12, lungs clear bilateral. Addendum: Pulse oximetry (PO) 88% room air (RA).) Oxygen (02) applied at 3-liter L via nasal cannula (NC). On 7/07/20 at 6:00 a.m., physician assistant (PA), on call for primary care physician, notified of decline in status, unable to reach family for notification -phone # ringing no longer in service. New order sends to emergency room (ER) for evaluation initiated. On 7/07/20 6:30 a.m., the nurse documented Transport to emergency room (ER) at this time via emergency medical services (EMS). On 7/07/20 10:00 a.m., the nurse documented (Health Care) Power of Attorney (POA) was notified of transfer to ER. Further review of the clinical record for Resident #892 on 7/07/20 at 6:00 a.m., on the situation background assessment recommendation (SBAR) communication form revealed Unresponsive, COVID-19 positive, changes in the last week. No change, unresponsive, limb flaccid, shallow respiration HR 56. On 8/25/20 at 11:30 a.m., an interview was conducted with the DON, the assistant director of nursing (ADON) interim and Regional Registered Nurse (RRN) they said we agree with you our nurse did not provide timely care to the resident with a reported change in condition, specifically, critical vital signs. The nurse did assess the resident but from the nurse documentation we are unable to find any further documentation to prove the nurse actually called the physician on call and what the physician on call response regarding those critical vital signs were. On 8/25/20 at 11:57 a.m., a telephone interview was conducted with physician assistant (PA) he said Resident #1 was a long-term care (LTC) resident. Our medical practice for long term care (LTC) residents is to visit once a month. I knew she was a DNR, and on 7/07/20 I gave the nurse an order to send the resident to the hospital because she was unresponsive, I remember the family was not answering the phone so we could not notify them of the transfer. I was aware she was COVID-19 positive but after the positive result she stayed asymptomatic.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** Based on record review and staff interview, the facility failed to ensure medical records contained accurately documented information for end of life care for 1 (Resident #892) of 4 sampled residents. The findings included; The facility's Policy N-105 Notification of Change in Condition (revised 9/21/17) indicated The nurse to complete an evaluation of the Patient/Resident. Document evaluation in the medical record. Notify the residents representative of the change in condition and document notification in the medical record. Review of Resident #892's clinical record revealed a State of Florida Do Not Resuscitate Order signed by the resident and physician on 7/16/13. Review of the nursing notes for Resident #892 revealed on 7/4/20 on the 7 a.m. to 3:00 p.m. shift, Licensed Practical Nurse (LPN) Staff L documented the physician was notified of the resident refusing most food and liquids, refusing medications and the residents current vital signs to

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 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) include blood pressure of 122/70, temperature of 97.6 Fahrenheit, pulse 70 beats per min and respiratory rate of 20 per minute. There was no documentation of the physician's response or of the resident's representative being made aware of the change in condition. On 7/4/20 at 3:45 p.m., LPN Staff M documented on rounds, she noted Resident #892 with mild restlessness, with cold extremities, toes and fingers with cyanosis (bluish discoloration) temperature 96.8, heart rate 35 beats per min, blood pressure 77/54 and a call was out to MD services in regards to these findings. LPN Staff M documented the Director of Nursing (DON) was made aware of patient's status. There was no documentation of any MD response or family notification. On 7/4/20 there was no documentation by the day or evening shift nurse as to the resident's status or if comfort care was being provided. On 7/5/20 at 12:00 a.m. through 6:00 a.m., LPN Staff M documented the resident's status during her shift. There was no documentation by the day shift nurse. The evening shift nurse, LPN Staff M documented the resident's status and heart rate of 50 beats per minute, continued coldness and cyanosis to extremities and was unable to hear a blood pressure. LPN Staff M noted MD aware of decline. There was no documentation of when the notification was made, any new orders, or if the resident's representative was notified. On 7/6/20 at 6:00 a.m., LPN Staff M documented the resident's status and care being provided. On 7/6/20 at 2:00 p.m., the day shift nurse, LPN Staff L, documented the resident's condition was unchanged. There was no documentation by the evening shift nurse of care being provided or resident's status. On 7/7/20, there was no documentation about the resident's status until 5:45 a.m., when LPN Staff I noted the resident heart rate was 56 beats per minute, respiration rate of 12, and unable to obtain a blood pressure. LPN Staff I noted she attempted to contact the resident's representative. The physician was called, and a new order was received. In an interview on 9/15/20 at 11:40 a.m., LPN Staff L said she did call Resident #842's physician but failed to document his response. Staff L said she did try to contact the resident's POA but there was no answer. She confirmed she did not document this attempt. In an interview on 9/15/20 at 12:30 p.m., the DON acknowledged the incomplete documentation by the nurses providing end of life care to Resident #842. The DON said staff should be noting the physician response when contacted, care provided, and all attempts made to notify the resident's representative.