STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105416	A. BUILDING _____ B. WING _____	**07/29/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BENEVA LAKES HEALTHCARE AND REHABILITATION CENTER	**741 SOUTH BENEVA ROAD SARASOTA, FL 34232**

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 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 record review, facility policy review, family and staff interview, the facility failed to provide physician ordered pressure ulcer treatment for 1 (Resident #16) of 3 residents sampled. The failure to provide wound care as ordered had the potential to contribute to the pressure ulcers worsening. The findings included: Review of the facility policy, Clinical Guideline Skin & Wound Document Name: WC-100, effective date 04/01/2017 showed, To provide a system for identifying skin at risk, implementing individual interventions including evaluation and monitoring as indicated to promote skin health, healing and decrease worsening of/prevention of pressure injury. On 7/29/20, record review of the Initial Wound Evaluation & Management Summary form completed by the Wound Physician dated 2/7/20 for Resident #16 noted the presence of a Stage 3 pressure wound, (a wound through the second layer of skin into the fat) of the left buttock, wound size, (length x width x depth) 2.5 x 2.0, depth not measurable. A daily treatment with calcium algenate was ordered to promote healing and there were recommendations to off load the wound and reposition per facility protocol. On 7/29/20, record review of the medication/treatment administration forms from 2/7/20 to 2/14/20 for Resident #16 showed wound care orders were not documented as completed. There was no evidence the ordered treatment to the left buttock was administered on 4 consecutive days from 2/11/20 to 2/14/20. On 7/29/20, record review of the Wound Evaluation & Management Summary form completed by Wound Physician on 2/14/20 noted the Stage 3 pressure wound to the left buttock had increased in size to 6 cm x 4.5 cm x not measurable (length x width x depth) and assessment of the wound progress was noted as Deteriorated. The treatment to the area was changed and there were again, recommendations to off load the wound and reposition per facility protocol. On 7/29/20, review of the Wound Physician documentation dated 2/14/20 showed a Stage 3 pressure wound of the right shin measuring 1.5 cm x 0.5 cm x not measurable, (length x width x depth). This wound was not documented as being present on the 2/7/20 Wound Physician note. The initial admission data collection form dated 2/6/20 noted a skin tear to the right lower leg (front) but there was no documentation of the area being a pressure wound. An order was recieved for a once a day treatment with a dry protective dressing to apply for 30 days. There was a recommendation to off load the wound and reposition per facility protocol. On 7/29/20, record review of the Baseline Care Plan and Summary revealed a blank Altered Skin Integrity/Potential care plan dated 2/6/20 at 4:10 p.m. No areas of altered skin integrity were identified on admission. No new areas of altered skin integrity had been documented since admission. No resident goals or interventions were documented on the care plan form. The Wound Physician orders and recommendations had not been incorporated into the baseline care plan. On 7/29/20 at 11:00 a.m., during an interview, Resident #16's father said his son was admitted to the facility on [DATE] from a local hospital. He said his son had been bed bound for many years with [MEDICAL CONDITION], (a potentially disabling disease of the brain and spinal cord). He stated, they (the facility) weren't doing anything they were supposed to do for my son's wounds. He said his son was supposed to be rolled every two hours, but his son was always on his left side. He said his son had a wound on his right shin that did not have a dressing and he had to demand a cover for the wound. He said his son's wounds worsened during his time in the facility. On 7/29/20 at 3:40 p.m., during an interview, Licensed Practical Nurse Staff E acknowledged working on 2/11/20 through 2/14/20. LPN Staff E reviewed the medication/treatment administration forms with missing sign offs which failed to show the wound care was completed. She said if I was working, I did the wound care. She also said, I learned in school if it's not documented it's not done. On 7/29/20 at 3:00 p.m., in an interview, the Director of Nursing said she reviewed resident #16's Baseline Care Plan for Altered Skin Integrity/Potential and acknowledged the care plan was incomplete.
F 0726 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** Based on record review and interview the facility failed to ensure the training and competency for administering intravenous (IV) medications for 3 (Staff A, B, and C) of 6 Licensed Practical Nurses (LPN) surveyed resulting in a potential for adverse effects including but not limited to infection of the IV site, infiltration of the IV site and reaction to medications due to improper administration. The findings included: The Florida Administrative Code shows, .the course necessary to qualify a licensed practical nurse or graduate practical nurse to administer IV therapy shall be not less than a thirty (30) hour post-graduate level course teaching aspects of IV therapy containing the components enumerated in subsection 64B9-12.005(1), F.A.C. Review of Resident #20's May 2020 Medication Administration Record [REDACTED]. LPN Staff B documented she administered the IV antibiotic to Resident #20 on 5/10/20. LPN Staff C documented she administered the IV antibiotic to the Resident #20 on 5/11/20. Review of Resident #21's June 2020 MAR indicated [REDACTED]. On 7/29/20 at 12:30 p.m., in an interview, the Assistant Director of Nursing (ADON) said she could not find documentation of the 30-hour training for post graduate LPN's for IV administration for Staff A, Staff B, or Staff C. The ADON said she was sure Staff C had the training because she had been working at the facility for a long time. On 7/29/20 at 12:55 p.m., in an interview LPN Staff B said she did not have the 30-hours of training required for LPN's to administer IV medications. Staff B denied she was actually administering the medication. She stated the registered nurse on shift would hang the medication and she would watch and document the medication was given. Staff B stated that she understood the person who initialed the form was verifying they administered that medication. On 7/29/20 at 1:07 p.m., in an interview, LPN Staff C said she had the 30-hours of IV medication training a long time ago in another state and she would not be able to produce documentation of the training. Staff C denied she hung the IV medication. She said she would monitor the medication while it was hanging and take the medication down when it was finished. On 7/29/20 at 1:24 p.m., in an interview LPN Staff A denied that she ever administered IV medications to residents. She said she documented she had because the registered nurses would not come back and document they had hung the medications. She said sometimes the registered nurses would give her attitude when she asked them to hang an IV that was ordered on her assignment. She said there were times when she could not find anyone to hang the medication and she would have to leave it for the next shift, and they would get upset at her. On 7/29/20 at 1:40 p.m., in an interview Registered Nurse Staff D said he would sometimes hang IV's for the LPNs if they were having difficulties or they were busy. He said he was not aware there were any LPNs who were not trained to administer IV medications. He said he assumed if they had a license to practice nursing, they could administer IV medications. He said he was never told by the administration some of the LPNs were not trained to administer IV medications.

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