STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105986	A. BUILDING _____ B. WING _____	**06/19/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ADVENTHEALTH CARE CENTER ZEPHYRHILL NORTH	**7350 DAIRY RD ZEPHYRHILLS, FL 33540**

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 observations, interviews and record reviews the facility failed to provide assistance with bed mobility and positioning for vulnerable dependent residents as needed for 2 residents (#17, #18) out of 18 residents sampled. Findings included: An interview was conducted on 6/19/2020 at 2:50 p.m., the Director of Nursing (DON) said, We follow the standard of practice and re-positron residents at least every 2 hours and more often if needed. 1. An observation was conducted on 6/19/2020 at 10:49 a.m., Resident #17 was in her room with the door halfway closed and the blinds closed. Resident #17 was in her bed positioned on her right side towards the window with a pillow observed underneath her back. There was no television or radio on. The bathroom light was off. A second observation was conducted on 6/19/2020 at 11:41 a.m., Resident #17 was in her room with the door halfway closed and the blinds closed. Resident #17 was in her bed positioned on her right side towards the window with a pillow observed underneath her back. There was no television or radio on. The bathroom light was off. A third observation was conducted on 6/19/2020 at 1:00 p.m., Resident #17 was in her room with the door halfway closed and the blinds were closed. Resident #17 was in her bed positioned on her right side towards the window with a pillow observed underneath her back. There was no television or radio on. The bathroom light was off. Resident #17 was still positioned on her right side with a pillow underneath her back. An interview was conducted on 6/19/2020 at 1:15 p.m., Staff F, Certified Nurse's Aide said, I have not positioned her yet. I am sure I turned her when I came in today. A review of the Minimum Data Set (MDS) for Resident #17 dated 4/17/2020 revealed a Brief Interview for Mental Status (BIMS) score of 8 out of 15 which indicates the resident is moderately cognitively impaired. A review of Section G for Assistance with Daily Activities of Living (ADL's) for Bed Mobility for self-performance it is documented a score of 3 that the resident required extensive assistance with moving to and from a lying position, turning from side to side, and positions body while in bed. Documented under the column for 2. Support a score of 3 is documented which indicates the resident requires 2 plus persons physical assistance with bed mobility. A review of the care plan for Resident #17 initiated on 8/28/2018 and revised on 2/19/2020, revealed a Problem Area that Resident #17 has an ADL self-care performance deficit related to stroke. Documented under Interventions/Tasks: Bed Mobility: The resident requires Extensive assist of 2 staff to turn and reposition in bed as necessary. An interview was conducted on 6/19/2020 at 6:12 p.m., a family representative said, Positioning of Resident #17 has always been a problem. We have complained about it on many occasions. I would not be surprised. It is so hard on us right now. We cannot get in there to see what they are doing. This has been so hard. 2. An observation was conducted on 6/19/2020 at 10:50 a.m., Resident #18 was in her room lying on her back, uncovered with a shirt and a brief on. The resident cried out saying, Can someone help me get up. I have been calling for someone, but I can't get anyone to come. A second observation was conducted on 6/19/2020 at 11:31 a.m., Resident #18 was still in her room in her bed lying on her back. The resident had on a shirt and brief. The resident was not covered up. An interview was conducted at 11:31 a.m., Resident #18 said, No one has been in here. A third observation was conducted on 6/19/2020 at 1:18 p.m., Resident #18 was still in her room in bed lying on her back uncovered with a brief and shirt on. An interview was conducted at 1:19 p.m., Resident #18 said, Can you please get someone in here to help me? The residents call light was stuck between the side rail and the mattress of the bed not within the resident's reach. An interview was conducted on 6/19/2020 at 1:20 p.m., Staff G, CNA said, I am going in to check on Resident #18 now. A review of the Minimum Data Set (MDS) for Resident #18 dated 5/15/2020 revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicates the resident is mildly cognitively impaired. A review of Section G for Assistance with Daily Activities of Living (ADL's) for Bed Mobility for self-performance it is documented a score of 3 that the resident requires extensive assistance with moving to and from a lying position, turning from side to side, and positions body while in bed. Documented under the column for 2. Support a score of 3 is documented which indicates the resident requires 2 plus persons physical assistance with bed mobility. A review of the care plan for Resident #18 initiated on 2/04/2020, revealed a Problem Area that Resident #18 has an ADL self-care performance deficit related to deconditioning, weakness and impaired mobility status [REDACTED]. Documented under Interventions/Tasks: Bed Mobility: Extensive x 1. A review of the medical record for Resident #17 at 1:30 p.m., revealed documentation under the Aide Task areas that the resident had been positioned on 6/19/2020 at 00:06 and at 10:56 a.m. An interview was conducted on 6/19/2020 at 2:50 p.m., with the Nursing Home Administrator (NHA), DON, LPN/Infection Control Preventionist, ADON/education RN the DON said, Our expectations would be staff are to reposition employees every 2 hours. A policy for turning and positioning was requested.
F 0757 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record reviews the facility failed to ensure there were no unnecessary medications by not including an indication for use in the order for each medication for 1 (#1) resident out of 18 records sampled. Findings included: A review of the Medication Administration Record [REDACTED]. an order for [REDACTED]. Levetiracetam tablet 1000 mg Give 1 tablet by mouth two times a day for Health Maintenance with a start date of 1/11/2020 at 0900. [MEDICATION NAME] /tablet 10 mg Give 1 tablet by mouth two times a day for Health Maintenance with a start date of 1/11/2020 at 0900. An interview was conducted on 6/19/2020 a 2:50 p.m., the Director of Nursing (DON) said, I noticed that some of the medication administration records have the purpose of the medications listed as Health Maintenance. We need to write those orders over. We need to correct those records. An interview was conducted on 6/19/2020 at 6:30 p.m., with the pharmacist on call said, All medications should include why the resident is taking the medication. What is the [DIAGNOSES REDACTED].? I am not sure why those say that. I will need to look into it.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** Based on observations, interviews and record reviews the facility failed to follow an infection prevention and control program by 1. not ensuring urinary catheters and tubing were positioned up off the floor for 2 (#15, #12) residents out of 16 residents with an indwelling or external urinary catheters and 2. not ensuring staff performed hand hygiene before and after resident contact on 1 of 2 nursing units. Findings included: 1. An observation was conducted at 10:46 a.m., Resident #15 was in his bed and his urinary catheter bag and tubing were on lying on the floor. (Photographic evidence was obtained.) An observation was conducted at 10:54 a.m., Resident # 12 was in his wheel chair sitting in front of his bed with his Foley catheter bag and tubing touching the floor. (Photographic evidence was obtained). A second observation was conducted at 12:28 p.m., Resident #15 catheter and tubing were still on the floor. An interview was conducted at 12:36 p.m., Staff A, Licensed Practical Nurse (LPN), confirmed the catheter and tubing were on the floor. A second observation was conducted on 6/19/2020 at 1:02 p.m., Resident #12 was in his bed and his catheter and tubing were lying on the floor on

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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) the window side of the bed not hooked on the bed. An interview was conducted on 6/19/2020 at 1:02 p.m., Resident #12 said, my Foley catheter bag is on the floor like that a lot. They put me in bed and then they forget to hook the bag onto the bed. An interview was conducted at 1:04 with Staff A, LPN and she confirmed both findings of the catheter on the floor for Resident #12 and #15. Staff A, LPN said, No, the Foley catheter bag and tubing should not be on the floor. I will fix them. An interview was conducted on 6/19/2020 at 1:45 p.m., with the DON, NHA, Infection Preventionist and the ADON. The DON and NHA reviewed the photographic evidence obtained and confirmed that catheters and urinary tubing should not be on the floor. The DON said, No, they should not be on the floor. 2. An observation was conducted on 6/19/2020 at 11:12 a.m., Staff B, Certified Nurses Aide (CNA), was in the room with the residents in Adams Hall 5-picking up items up off of the floor. Staff B, then came out of Adams 5 and walked into Adams 7 and did not perform hand hygiene after contact with objects in the residents' immediate surroundings. An interview was conducted on 6/19/2020 at 11:13 a.m., Staff B, CNA confirmed she had not washed or sanitized her hands after leaving the room. A review of the facility policy titled Infection Prevention original date of 9/19/2011 and revised on 1/04/2018, Policy: It is the policy of this facility to provide a safe, sanitary, and comfortable environment. this facility will investigate, control, and attempt to prevent the development and transmission of infections. The Infection prevention and control program will identify, investigate and control infections and communicable diseases for all residents, staff, volunteers, visitors and other contracted individuals. Procedure: 4. The facility will provide precautionary measures to prevent the spread of potential infection, while monitoring resident's progress .