STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105146	A. BUILDING _____ B. WING _____	09/23/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VENTURA HEALTH AND REHABILITATION CENTER	7900 VENTURE CENTER WAY BOYNTON BEACH, FL 33437

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 observation, staff interview and clinical and administrative record review, the facility staff failed to provide the necessary care and services for 2 of 4 sampled residents (Resident #1 and #7) reviewed for pressure ulcers. This is evidenced by the staff failure to adhere to the prescribed wound treatment plan; and failed to provide evidence of timely assessments and interventions for residents admitted to the facility with skin issues. The findings included: 1. Review of the clinical record for Resident #1 revealed the resident was admitted to the facility on [DATE]. The hospital's 3008 form noted the resident had a rash on her buttocks area. The facility's admission assessment documented the resident was high risk for the development of pressure ulcers and identified the following: The resident had a Stage II pressure ulcer on her right buttocks measuring 5 cm x 5 1/2 cm. The Stage 2 Pressure Ulcer: Partial-thickness skin loss with exposed dermis. Partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink or red, moist, and may also present as an intact or open/ruptured blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. Despite the admission assessment identifying that the resident had an open area on her buttocks, the facility did not implement a treatment plan until 5 days later on 07/02/20, when the physician prescribed to cleanse the area with normal saline, pat dry, apply calcium alginate plus gauze and cover with the dry dressing daily. The resident's wound began to deteriorate and the physician changed the resident's treatment orders and on 08/26/20. The physician prescribed to increase the frequency of the wound dressing to cleanse sacral wound with normal saline, pat dry, apply Dakins 0.5% moisten gauze, 4 x 4, dry dressing twice daily and as needed. Review of the Treatment Administration Record (TAR) for the corresponding order, documented 'once daily' implementation and the staff did not perform the 'twice daily' dressing changes as prescribed. Additionally, review of the Wound Care physician progress notes [REDACTED]. Fungal rash noted to peri-wound involving bilateral buttock. [MEDICATION NAME] Cream noted. Necrotic tissue debrided. There is no evidence that the [MEDICATION NAME] Cream was implemented to treat the resident's periwound fungal rash. An interview was conducted with the Director of Nursing (DON) on 09/21/20 at 1:15 PM. The surveyor reviewed with the DON the identified irregularities regarding the resident's wound care and assessments. Although the DON was aware of some irregularities with wound care, the DON confirmed she was not aware the staff did not perform the twice daily wound care or the [MEDICATION NAME] cream. An interview was conducted with the Wound Care Nurse on 09/21/20 at 3:40 PM. The surveyor reviewed the identified concerns regarding the wound care for the resident. She confirmed she was aware of the twice daily wound care but did not put it into the computer correctly thus the wound care was not done twice daily as prescribed. 2. Review of the clinical record for Resident #7 revealed that the resident was admitted to the facility on [DATE]. The Admission Data Set identified that the resident had an open area on the sacrum. The Braden Scale assessment noted the resident as high risk for the development of Pressure Ulcers. There was no further information regarding the noted area to complete the assessment to note a full description of the area. There was no treatment orders noted in the clinical record as of 09/21/20 (6 days after the resident's admission). An interview was conducted on 09/21/20 at 3:15 PM with Staff A, Registered Nurse, who reported that she cared for the resident on this date. The surveyor inquired about whether or not the resident had skin issues. She confirmed that the resident had a small open area on admsssion and proceeded to draw a small line to indicate the open area. The surveyor then inquired about treatment for [REDACTED]. She stated that the resident's wound care was done this morning by the Wound Care Nurse. An interview and observation was conducted on 09/21/20 at 3:30 PM with the Licensed Practical Nurse, Staff D, who stated she first observed an area on the resident buttock last week and at that time, it was just redness and she put barrier cream on the area. Observation of the resident revealed an approximate area of 2 inches x 2 inch non blanchable red area and an approximately 1 x 1 excoriated area within that redden area. A telephone interview was conducted on 09/21/20 at 3:45 PM with the Wound Care Nurse, who reported that she was not aware that Resident #7 had any skin issues and had not performed treatments on the resident on this date. The surveyor inquired how are skin issues identified, as other than the notation on the Admission Data Set, there is no further indication the resident had skin issues. She stated that if the Admission Assessment is completed by a Registered Nurse (RN), the RN can do the initial assessment and she has to review to initiate care. If the admission is done by a LPN (licensed practical nurse), she will complete a second skin check by the next day and document and initiate care as necessary. She further confirmed, she was running behind with admission residents.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview and clinical and administrative record review, the facility failed to ensure three staff observed implemented the appropriate transmission precautions for new admissions with unknown status and residents exposed to [DIAGNOSES REDACTED] C0V-2 on two wings in the facility; and failed to follow the appropriate hand hygiene protocols when changing gloves during the observance of wound care for one (1) of 4 sampled residents reviewed for wounds, Resident #3. The findings included: Review of the facility's policy and procedure for Isolation Precautions, Categories of, dated April 1, 2020, documented Transmission-based isolation precautions have been established in order to ensure that appropriate isolation techniques are implemented in this Center when necessary. Further documentation regarding Droplet Precautions noted, In addition to Standard Precautions, Droplet Precautions must be implemented for a resident documented or suspected to be infected with microorganisms transmitted by droplets (large-particle droplet that can be generated by the resident coughing, sneezing, talking, or the performance of procedures). a. Mask 1) In addition to wearing gloves as outlined under Standard Precautions, wear gloves (clean, nonsterile) when entering the room as well as a gown and mask. 2) Remove the mask, gloves, and gown before leaving the resident's environment. 3) After gown/glove/mask removal, ensure that clothing does not touch potentially contaminated environmental surfaces. The facility's policy regarding Coronavirus (COVID-19) Precaution Plan, dated September 11, 2020, documented regarding New Admissions/Readmissions: New admissions/Readmissions with unknown COVID-19 status will be placed in droplet isolation for 14 days to observe for signs/symptoms of COVID-19. If symptoms present, consider testing for COVID-19 (if testing supplies are available). The policy further noted regarding Systemic Changes for COVID-19 Positive Staff Member: Use contact tracing to identify potentially exposed patients that the positive staff member had close contact with 48 hours prior to symptom onset or 48 hours prior to test date for asymptomatic staff with positive results for duration of time until staff member sent home (which date is most recent) and begin the following: Quarantine (not coming out of room-only in room therapy, if applicable) Droplet isolation precautions Activate Respiratory UDA to check respiratory status/vitals daily. The (CDC definition of close contact: For COVID-19, a close contact is defined as any individual who was within 6 feet of an infected person for at least 15 minutes starting from 2 days before illness onset (or, for asymptomatic patients, 2 days prior to positive specimen collection) until the time the patient is isolated.) 1. An observational tour conducted on 09/18/20 beginning at 10:00 AM on the 300-wing revealed the resident in room [ROOM NUMBER] was noted to have a Droplet precautions sign on the door. The resident was a new admission of 09/15/20. There was no isolation personal protective

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) equipment (PPE) outside the room or readily available for the staff to utilize. Staff B, Registered Nurse, entered the resident's room, wearing the same mask, she had been previously wearing to administer medications to the other residents on the unit. The nurse went into the resident's room provided the necessary care and services and when she came out, the nurse did not change her mask upon exiting this resident's room who is currently on droplet precautions. The nurse then went to the room of the resident in room [ROOM NUMBER]. The resident was not on any isolation precautions. The resident in room [ROOM NUMBER] also has several respiratory issues and was wearing oxygen. Further investigation revealed the resident in room [ROOM NUMBER] had been admitted on [DATE] and according to the facility's policy, the resident is to remain on droplet precautions for 14 days after admission (to observe for signs/symptoms of COVID-19). An interview was conducted on 09/18/20 at 11:47 AM, with Staff B, who stated the correct protocol for Droplet Precautions of removing the mask, gown and gloves and performing hand hygiene prior to leaving the resident's room. She confirmed she did not follow infection control procedures for removing her mask when she left room [ROOM NUMBER]. 2. An observation conducted on 09/18/20 beginning at 11:05 AM, noted signs indicating Droplet Precautions on rooms [ROOM NUMBERS]. There were no PPE supplies available in close proximity. Interviews were conducted with the staff nurses on that unit, Staff C and Staff I. They both stated that they did not have any residents on Droplet Isolation on their respective assignments. The surveyor then inquired about the residents in rooms [ROOM NUMBERS]. Staff C was the nurse assigned to provide care and services to these residents and she stated those residents were on contact isolation not droplet isolation. She checked the electronic record for the residents and stated the residents were on contact isolation, but she would check with the Director of Nursing to confirm as she (DON) was the one who probably put those signs up. After consulting with the DON at 11:10 AM, she stated the residents were exposed to a staff who tested positive for COVID 19 on 09/17/20, thus the resident was placed on droplet precautions on 09/17/20. She stated she (Staff C) did not work on 09/17/20 and came back today and thought they were on contact isolation. Staff C is the 7 AM - 3 PM nurse. The staff are informed of the type of transmission-based precautions during staff report or by the DON. Later observations on the 100-wing beginning at 12:00 PM revealed additional rooms with Droplet Precautions on Staff C's assignments (rooms 113, 114 - 2 residents; rooms 116, 118 - 2 residents; and room [ROOM NUMBER] - 2 residents). Despite these rooms having the signage for the Droplet precautions, there was no PPE storage outside the doors for these rooms. The residents in room [ROOM NUMBER] (2 residents) were also on Droplet Precautions. These residents were placed on droplet precautions secondary to their exposure to a staff who tested positive for COVID-19 on 09/17/20. Observation at 12:10 PM revealed Certified Nursing Assistant (CNA), Staff H, went into room [ROOM NUMBER]. After providing services in the room with the residents, the CNA exited the room wearing the same mask she entered the room with. She then discarded the food tray and walked down the hall to the utility room. The aide changed her mask in the dayroom on the unit and discarded it in the trash. 3. Observation of the wound care for Resident #3 was conducted on 09/18/20 beginning at 11:20 AM with Staff F, Assistant Director of Nursing and the Wound Care Nurse. Staff F performed the wound care and failed to perform hand hygiene between glove changes three times when the nurse used a dry dressing and cleaned inside the wound bed, changed her gloves and failed to perform hand hygiene between removing the gloves used to handle the soiled dressing and applying clean gloves. After cleaning the wound and discarding the soiled dry dressing, the nurse used two clean 4 x 4 gauze dressings soaked with Dakins' solution and packed the resident's wound. The nurse again changed her gloves and donned a new pair of gloves but did not perform hand hygiene between glove changes. The nurse applied skin prep to the peri-wound and changed her gloves but again Staff F failed to perform hand hygiene between glove changes. An interview was conducted Staff F following the above observation at 11:43 AM to review the above observation. Staff F confirmed she did not perform hand hygiene between each glove change. The facility's policy regarding Hand Hygiene dated November 2019 documented Associates must perform appropriate handwashing procedures under the following conditions, which included: After removing gloves. Hand hygiene (HH) (e.g. handwashing and/or alcohol-based hand rub (ABHR) Soap and other detergents help in the cleansing process. The Association for Professionals in Infection Control and Epidemiology (APIC) is creating a safer world through the prevention of infection, documented information regarding Gloved Hands May Spread Germs, Vinyl, latex and [MEDICATION NAME] gloves protect the skin from body fluids and certain harmful chemicals. The surface of gloves can support germs just like skin. But, unlike skin, washing gloves is not an option. Even healthcare workers are instructed to wash their hands before they put on gloves and after taking off gloves. Gloves are not a substitute for hand washing.