STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105519	A. BUILDING _____ B. WING _____	**05/19/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NSPIRE HEALTHCARE PLANTATION	**6931 W SUNRISE BLVD PLANTATION, FL 33313**

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 interview and record review, the facility failed to timely review and re-evaluate an ophthalmic condition, resulting in the likelihood of [MEDICAL CONDITION] in that eye, for 1 of 3 residents reviewed, Resident #1. The findings included: Record review revealed Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. An Admission Comprehensive Assessment, dated 05/01/20, documented the resident as severely cognitive impaired and required extensive to total two-person assistance with activities of daily living. A review of Resident #1's progress notes revealed an admission progress note, dated 04/24/20 at 9:00 PM, that documented, There is redness and swelling to the right eye. Further review of the resident's progress notes revealed a progress note, dated 04/29/20 at 3:33 PM, that documented, Resident right eye swelling and red. Physician was notified and family notified. A progress note, dated 04/30/20 at 12:32 PM, documented, Resident assessed by the nurse this morning. No complaints voiced. Seen via telehealth with Physician, who was notified of the right swelling and red eye. She could assess the right eye via camera. She said she would prescribe antibiotics (6 days after admission to the facility). An interview was conducted with the Director of Nurses (DON) on 05/19/20 at 2:00 PM. The DON stated he observed Resident #1's eye, and it was quite swollen and red. The DON further stated he was the one who initiated the telehealth visit with the physician. At approximately 5:00 PM, the DON stated the resident had no falls while at the facility. A review of the physician's progress notes of the telemedicine visit, dated 04/30/20, documented, Patient appears to be well and in no distress. No shortness of breath. Acutely ill, appears disoriented. His breathing appears to be normal in rate, chest expansion is normal, no audible wheezing. Face is somewhat asymmetric, [MEDICAL CONDITION] at right eye with discharge. Patient is disoriented, mood is appropriate. Abrasions on coccyx, right elbow, right knee, and right shoulder. Review of the Treatment plan/referrals documented, abrasions/open area to coccyx, right elbow, right knee, and shoulder; continue routine wound care. [MEDICAL CONDITION]: [MEDICATION NAME]. Further review of the resident's record revealed the resident was started on [MEDICATION NAME] (blood thinner) daily for [MEDICAL CONDITION] ([MEDICAL CONDITION] [MEDICATION NAME] on 04/28/20 for 14 days (05/12/20). The [MEDICATION NAME] eye drops (both eyes) 4 times a day was started on 04/30/20 x 7 days (05/07/20). Review of Resident #1's records lacked any evidence of a re-evaluation by the nurse or the physician of the resident's right eye after completion of the eye antibiotics on 05/07/20. There was no further documentation of whether the resident's eye improved or worsened after the treatment was completed. Resident #1 was transferred to the hospital on [DATE] for unresponsiveness. A review of the emergency provider report, dated 05/14/20 at 9:47 AM, documented: chief complaint unresponsiveness, history obtained from EMS, unable to obtain history altered mental status. Patient unresponsive unable to obtain any medical history as per nursing home staff and EMS, patient was unresponsive. There is conflicting information whether patient has coronavirus or not. When EMS arrived, patient was hypoglycemic and given D10 ([MEDICATION NAME] 10% intravenously) with no response. Under focused physical examination, it was documented for eyes, proptotic right eye (bulging) with purulent discharge. Right pupil blown and non-reactive. Review of the CAT scan results of the orbits completed without contrast, dated May 14, 2020 at 12:30 PM, had the Impression documented as: CT interpretation / findings documented multiple right sided facial fractures noted with pro[DIAGNOSES REDACTED] of the right eye likely secondary to hematoma (a build up of a collection of blood). On the physician reevaluation, it was documented, patient has no pupillary response on the right eye is proptotic. The injury does not look acute. Unsure of any mechanism. On review of nursing home records, there is no history of a fall. Clearly some trauma has happened in the past. Patient had multiple episodes of [DIAGNOSES REDACTED] here. The patient has required 3 D 10 boluses (3 [MEDICATION NAME] 10%) with improvement of blood sugar. Patient placed on D 5 ([MEDICATION NAME] 5%) 1/2 Normal Saline for [MEDICAL CONDITION]. Spoke with patient's sister at length. She is aware there is nothing we can do regarding his right eye. He will likely be blind. Sister understands. Additional text documents patient's mentation is slightly improved with responsiveness to painful stimuli. Blood gas reveals good [MED]genation and ventilation. Mentation still not at baseline.[MEDICAL CONDITION] bundle was implemented. Patient received empiric antibiotics and IV fluids. Likely source of [MEDICAL CONDITION] is urinary tract infection.

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.