STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105484	A. BUILDING _____ B. WING _____	**03/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OKEECHOBEE HEALTH CARE FACILITY	**1646 HIGHWAY 441 N OKEECHOBEE, FL 34972**

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 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the accuracy of the MDS (minimum data set) for 2 of 29 sampled residents reviewed related to antianxiety usage (Resident #46, #134). The findings included: 1. Resident #46 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the MDS (Minimum Data Set) assessment reference date 12/24/19 revealed that under Section N for medications, sub-section B was coded incorrectly for antianxiety. The MDS was coded 0 in subsection B. Review of the Medication Administration Record, [REDACTED]. 2. Resident #134 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the MDS (Minimum Data Set) assessment reference date 02/17/20 revealed that under Section N for medications, sub-section B was coded incorrectly for antianxiety. The MDS was coded 0 in subsection B. Review of the Medication Administration Record, [REDACTED]. On 03/13/20 beginning at 2:11 PM, a side by side review of Resident #46 and Resident #134's records, and interview was held with the Director of Nursing. She acknowledged the findings.
F 0657 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to document attending physician involvement in the care planning process for 5 of 5 sampled residents reviewed (Residents #10, #92, #112, #113, and #151). This was identified as a system documentation issue with the potential to affect all residents. The census at the time of entrance was 177. The findings included: 1. Review of the record revealed Resident #10 was admitted to the facility on [DATE]. Review of the most current documented Interdisciplinary (IDT) Care Plan Review, dated 12/05/19, lacked any documented involvement of the physician. 2. Review of the record revealed Resident #92 was admitted to the facility on [DATE]. The most recent Minimum Data Set (MDS) quarterly assessment was completed on 01/25/20. Review of the IDT MDS (minimum data set) Care Plan Review, dated 01/30/20, lacked any documented physician involvement. 3. Review of the record revealed Resident #112 was admitted to the facility on [DATE] with the most current quarterly MDS assessment completed on 02/02/20. Review of the IDT MDS Care Plan Review dated 02/07/20 lacked any documented physician involvement. During an interview on 03/12/20 at 11:13 AM, Staff D, an MDS Coordinator was asked about physician involvement in the care planning process. The nurse identified the physician's quarterly note dated 02/19/20, twelve days after the care plan review, which lacked any care planning involvement with the IDT. During the continued interview on 03/12/20 at 11:26 AM, Staff D stated when issues arise at the quarterly care plan meetings, the physician will be notified and involved and there should be a follow up note. The MDS coordinator was asked how the physician's involvement in the IDT quarterly care planning process is completed and documented, even when there are no issues or changes, and the MDS coordinator had no response. 4. Review of the record revealed Resident #113 was admitted to the facility on [DATE] with most current MDS assessment for a significant change completed on 02/02/20 for a decline in several Activities of Daily Living (ADLs). Review of the IDT MDS Care Plan Review dated 02/06/20 lacked documented physician involvement. 5. Review of the record revealed Resident #151 was admitted to the facility on [DATE] with the most current quarterly MDS assessment completed on 0[DATE]. Review of the IDT MDS Care Plan Review dated 02/27/20 lacked any documented physician involvement. During an interview on 03/13/20 at approximately 3:00 PM, the Director of Nursing (DON) agreed with the lack of documented physician involvement in the care planning process. The DON stated they would continue to utilize the IDT MDS Care Plan Review forms with the addition of the physician.
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and policy review, the facility failed to ensure proper care and services for two of 2 sampled residents reviewed with a history of Urinary Tract Infections (UTIs), Residents #123 and #10. Two Certified Nursing Assistants (CNAs/Staff E and Staff F) failed to provide appropriate Foley (urinary drainage device) care to Resident #123. The facility failed to inform the physician of Resident #10's complaint of dysuria (pain with urination), in a timely manner. The findings included: 1. An observation on 03/11/20 at 8:56 AM revealed Resident #123 had a Foley catheter. The urine observed in the tubing of the catheter was cloudy. Upon arrival to the room of Resident #123 on 03/12/20 at 2:24 PM, Staff E, a CNA (certified nursing assistant) was preparing to provide personal care. The CNA used personal wipes throughout the process, wiping front to back multiple times. The CNA failed to wipe off or clean the Foley catheter during this process. The CNA placed a new brief on Resident #123, and found a pair of shorts for the resident. While threading the Foley tubing through the leg of the shorts, the CNA raised the Foley bag above the level of the resident's bladder and above the level of the bed, potentially allowing the urine to back flow into the bladder. During an interview after the observation, when asked why she did not clean the Foley tubing, the CNA stated, You made me nervous, but I can go do it now. The CNA was also informed of the concern related to raising the Foley bag above the level of the bladder, and stated Oh, I'm sorry. A second observation of personal care for Resident #123 was made on 03/13/20 at 9:54 AM, with Staff F, a CNA. Staff G, another CNA who assisted with positioning and cueing. Both CNAs washed their hands and gloved. Upon removal of the adult brief, soft stool was noted on the Foley tubing and on the front of the resident. Staff F cleaned Resident #123 using numerous wipes, but never separated the labia to ensure cleanliness. The CNAs assisted Resident #123 to her left side, and stool was noted on the wound dressing on the resident's sacrum. The CNA notified the nurse. After provision of wound care, Staff F told the resident she wanted to clean the front area again, to make sure I got everything. The CNA cleaned again on both sides, down the front without separating the labia, and again down the Foley catheter tubing. The CNA started putting the brief on, and the surveyor asked the resident if she could provide just a little guidance. Resident #123 encouraged the surveyor to do so, and the CNA was asked to separate the labia to ensure cleanliness. The CNAs finished donning the resident's brief and clothing. The Foley catheter strap was loose at the beginning of the observation, and was now completely apart. During an interview outside of the room, the CNAs were able to verbalize the rationale for cleaning thoroughly and use of the catheter strap. Staff G stated she would go fix the catheter strap. Review of the record revealed Resident #123 was admitted to the facility on [DATE], with the most current readmission on 01/30/20. Review of the current Significant Change Minimum Data Set (MDS) assessment dated [DATE], documented Resident #123 had a Brief Interview for Mental Status (BIMS) score of 11, on a scale of 0 to 15, indicating some cognitive impairment. This MDS also documented the use of the Foley catheter for a [DIAGNOSES REDACTED]. An additional order documented to keep the catheter below the level of the bladder. laboratory results dated [DATE] documented Resident

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105484	A. BUILDING _____ B. WING _____	**03/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OKEECHOBEE HEALTH CARE FACILITY	**1646 HIGHWAY 441 N OKEECHOBEE, FL 34972**

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 0690 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) #123 had a UTI. Review of the care plan dated 01/31/10 documented Resident #123 required a catheter for urination which places her at risk for UTIs. The goal was to be free from signs and symptoms of UTI, which was not met as of 02/23/20. Interventions included the use of the leg strap and provision of catheter care. Review of the document Catheter Care Policy reviewed 07/17/19 documented the policy is to provide catheter care in an effort to reduce bladder and kidney infections. Care for females included to gently separate the labia to expose the urinary meatus, and to clean the catheter with a new moistened cloth. 2. During an interview on 03/10/20 at 3:51 PM, Resident #10 stated it [MEDICAL CONDITION] she urinates. The resident stated she had not yet told anyone, as it just started, and was asked to put on her call bell to inform the staff. A random CNA answered the call light, was told about the new complaint by Resident #10, and the CNA stated she would let the nurse know. Review of the record revealed Resident #10 was admitted to the facility on [DATE]. Review of the current Minimum Data Set (MDS) assessment dated [DATE], documented Resident #10 had a BIMS score of 15, indicating the resident was cognitively intact. Review of the current care plan dated 09/04/18 at risk for increased incontinence/UTI, with updates as recent as 03/04/20, with a goal to remain free from signs and symptoms of a UTI, included the interventions to monitor for dysuria and report any abnormalities to the Nurse Practitioner (NP) or physician. During an interview on 03/13/20 at 12:50 PM, the Infection Control Coordinator explained Resident #10 was seen by the NP today related to the resident's complaint of burning, and explained the current antibiotic was discontinued in order to get another urinalysis next week. When asked if the NP or physician was notified of the dysuria earlier in the week, the Infection Control Coordinator stated she was unsure. During an 03/13/20 at 1:07 PM, Staff H, a Licensed Practical Nurse (LPN) confirmed she was told of the resident's complaint of dysuria Tuesday afternoon (03/10/20). When asked if she reported it to the physician at that time, the LPN stated she did not as it was late in the afternoon, and further stated that she informed the NP today. The LPN stated she may have passed on the information to the next shift via email. Review of her email information for the next shift on 02/10/20 lacked any report regarding Resident #10 . The LPN explained Resident #10 was already on an antibiotic but agreed she should have informed the physician of the resident's complaint.
F 0810 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide special eating equipment and utensils for residents who need them and appropriate assistance.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure adaptive equipment was available for 1 of 3 sampled residents reviewed with nutritional concerns (Resident #113). The findings included: An observation of Resident #113 was made on 03/11/20 at 5:25 PM through 5:48 PM in the main dining room. Resident #113 was eating slowly but independently, using regular utensils and drinking cups. The resident was having some difficulty using the utensils and drinking the fluids, having to grasp the items multiple times. A second observation was made on 03/12/20 at 12:31 PM. Resident #113 was again in the main dining room, but had double handled cups for drinking the fluids. The resident was using these cups effectively. The menu ticket documented the use of these cups. Review of the record revealed Resident #113 was admitted to the facility on [DATE], with the most current readmission on 04/25/18. Review of the Minimum Data Set (MDS) assessment for a significant change dated 02/02/20, documented Resident #113 had a Brief Interview for Mental Status (BIMS) score of 3, indicating the resident was severely cognitively impaired. Further review of the record revealed an order dated 02/14/20 for the use of the 2 handled cups, with the current care plan with the same intervention. During an interview on 03/12/20 at 1:15 PM, the consultant Registered Dietician (RD) was made aware of observations of previous evening without the adaptive equipment, and agreed with the concern.
F 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide food that was prepared, stored and served in a manner to prevent the growth and spread of pathogens that cause foodborne illness. The findings included: 1. During the initial kitchen tour, on 03/10/20 at 9:53 AM, with Staff A, Kitchen Supervisor, and Staff B, Supervisor/Lead Cook, the following observations were made: a. The drain cover from the drain of the mechanical ware washing machine was dislodged from the floor. b. Bus tubs that were used for maintaining proportioned cartons of fluids, juices , milk, were noted to be wet-nesting on a shelf with cleaned and sanitized equipment in the mechanical ware washing area. c. The handle of the stand mixer was encrusted with food residues. d. Cleaned and sanitized 4 inch deep, full sized hotel pans were noted to be wet-nesting on a shelf in a processing/food preparation area. e. There was an accumulation of food residues on the blade of the manual table mounted can opener. f. The internal temperature of a 4 inch deep sized hotel pan of carrots that was in the process of cooling, according to staff, in the walk in cooler was 46 degrees Fahrenheit (F). It was noted that the container was tightly wrapped in plastic wrap. Staff were instructed to discard the carrots. g. There was an accumulation of ice on the ceiling of the walk in freezer over packages of foods. During the tour, the facility's Registered Dietician Consultant arrived and joined the tour. The Registered Dietician Consultant, Staff A and Staff B verbally acknowledged understanding of the concerns. All temperatures were taken using the facility's calibrated, metal stem probe-style thermometer. 2.During a follow up tour of the kitchen, on 03/12/20 at 11:42 AM, accompanied by the Registered Dietician Consultant and the Certified Dietary Manager, the following observations were made: a. An open cart containing cleaned and sanitized plates and bowls was stored partially underneath the hand washing sink, exposing the equipment to splash over from handwashing. b. The internal temperature of a 6 inch deep sized hotel pan of chicken noodle soup that was hot holding on the line was 125 degrees F. Staff were instructed to re-heat the soup to an internal temperature of 165 degrees F before being served. c. The temperature of salads cold holding in a reach in cooler was 45 degrees F. It was noted that during the process of assembling the resident's meal trays for lunch (the meal being observed), the reach in cooler was open until intervention in the form of this surveyor requesting the temperature of the salads be taken. Staff were instructed to take the salads from the reach in cooler and cool them. d. Staff C, Cook, was observed wearing a watch on his arm while handing a product and assembling lunch trays. Staff C was instructed to removed the watch, wash hands and don clean single use gloves and return to assembling the trays. The Registered Dietician Consultant and the Certified Dietary Manager acknowledged the findings and understanding of the conerns. All temperatures were taken using the facility's caliberated metal stem probe-style thermometer. 3. On 03/11/20 at 9:30 AM, a small personal refrigerator was observed next to the window bed in resident room [ROOM NUMBER]. The resident was present at the time and stated it was his. Observation of the refrigerator revealed there was no thermometer present. The refrigerator contained a partial loaf of bread, a package of celery sticks, several containers of yogurt and a partial jar of white cheese dip. The bottom area of the refrigerator was significantly soiled with light brown matter. On 03/12/20 at 2:11 PM, the refrigerator was observed with no changes to the contents. On 03/13/20 at 10:40 AM, the refrigerator was brought to the attention of the Unit Manager. She observed and acknowledged the condition of the refrigerator and lack of thermometer. She stated she thought the residents were responsible for their personal refrigerators. She made a telephone call, and then stated it was the staff's responsibility to monitor and clean the residents' personal refrigerators. (Photographic evidence obtained.)