STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105495	A. BUILDING _____ B. WING _____	**09/14/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HILLCREST HEALTH CARE AND REHABILITATION CENTER	**4200 WASHINGTON ST HOLLYWOOD, FL 33021**

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 record review and interview, the facility failed to follow the care plan to ensure 1 of 3 residents (Resident #2) received weekly wound assessments, daily wound treatments as ordered, and interventions ordered and/or planned to prevent worsening of a right heel pressure ulcer. This contributed to Resident #2's pressure ulcer becoming infected with signs [MEDICAL CONDITION], for which she required hospitalization . The findings included: Resident #2 resided in the facility and was most recently readmitted on [DATE]. Resident #2's MDS (Minimum Data Set) Assessment with target date of 08/10/20 documents she was did not walk and was dependent on staff for transfers, dressing and toileting. Resident #2's Consulate Weekly Skin Integrity Review dated 07/31/20 at 11:10 AM documented a black area to the right heel measuring 8 cm (centimeters) by 6 cm. A wound consultant's Evaluation and Management Report by an Advanced Registered Nurse Practitioner for date of service 08/03/20 documents Resident #2 had a new unstageable pressure wound to the right heel with black necrotic (nonviable, dead) tissue in the wound bed. Resident #2's Pressure Ulcer Wound Rounds with effective date 08/03/20 at 5:41 PM document Resident #2 had an unstageable right heel pressure ulcer that measured 7.0 x 6.8 x 0.3 cm (centimeters) with black eschar in the wound bed. The National Pressure Injury Advisory Panel (accessed at https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf) defines an unstageable pressure ulcer as an obscured full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Resident #2's Care Plan documents a focus area for potential for pressure injury development, initiated on 12/08/18 and revised 08/03/20 for 8/2/20 DTI (deep tissue injury) to the right and left heel. Care plan interventions/tasks for this focus area that remained in effect since 12/08/18 were to administer treatments as ordered and monitor for effectiveness; monitor/document/report PRN (as needed) any changes in skin status; staff will assist to shift weight in bed and W/C (wheelchair); the resident needs assistance to turn/reposition at least every 2 hours, more often as needed or requested; and weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate. An intervention was added on 05/09/19 to apply Multipodus boots bilaterally as ordered to improve skin integrity, and added again on 08/03/20 for Multipodus boots as ordered. A clinician order dated 08/03/20 documents to change wound care orders for the right heel to use normal saline, apply [MEDICATION NAME], and cover with dry dressing every other day and as needed. Pressure Ulcer Wound Rounds with effective date 08/10/20 at 12:10 PM document Resident #2 had an unstageable right heel pressure ulcer that measured 7.0 x 6.8 x 0.3 cm with black eschar in the wound bed, and no drainage or odor. There was no evidence of documentation of a weekly skin or wound assessment on 08/17/20, or on any date between 08/10/20 and 08/24/20 except by a consulting Nurse Practitioner. The next skin assessment was a Consulate Weekly Skin Integrity Review with effective date 08/24/20 that did not indicate any wounds on an anatomic diagram, indicated yes for skin intact, and included a narrative note no new skin impairment noted at this time. Despite indicating skin was intact, the same nurse that conducted this skin assessment also documented completion of 2 different wound treatments to Resident #2's right heel, once with [MEDICATION NAME] and once with a new treatment of [REDACTED]. The wound consultant Nurse Practitioner's visit note for 08/24/20 documents Resident #2's right heel wound status was deteriorating with moderate serous (clear, watery) drainage and excessive black and yellow necrotic tissue, measuring 7 x 6 x estimated 0.4 cm depth. Resident #2's clinician orders on 08/24/20 included to discontinue current treatment to the right heel; and new wound care orders to cleanse the wound with normal saline, then apply 4x4 gauze moistened with Dakin's full strength (solution), and cover with dry dressing daily and PRN (as needed). Despite the order to discontinue current treatment to the right heel on 8/24/20, Resident #2's August 2020 Treatment Administration Record documented right heel treatments with saline, [MEDICATION NAME], and dry dressing continued to be performed every other day from 8/24 to 8/31, in addition to the new daily wound treatments to right heel with full-strength Dakin's solution. Resident #2's September 2020 Treatment Administration Record documented the (discontinued) right heel treatment with [MEDICATION NAME] was completed but not the currently ordered treatment with Dakin's solution. Review of the Resident #2's August 2020 Treatment Administration Record lacked documentation that orders were followed for (1) heel boots to be applied, (2) heels off-loaded, and (3) heel status checked every shift for deterioration during the day and night shifts on 08/20/20, or on day shifts 08/24/20 and 08/30/20. Review of the Resident #2's August 2020 Treatment Administration Record also lacked documentation that orders were followed to turn and reposition her every 2 hours in bed and every 1 hours in a chair for 9 AM, 11 AM and 1 PM each day on 08/20/20, 08/24/20, and 08/30/20. Resident #2's Consulate Weekly Skin Integrity Review dated 8/31/20 did not indicate any wounds on the anatomic diagram and indicated yes for skin intact. There was no evidence of documentation of a wound assessment for 08/31/20. However, the wound consultant Nurse Practitioner's visit note for 08/31/20 documents Resident #2's right heel wound had excessive black/yellow necrotic tissue and moderate serous drainage, measured 7 x 6 x estimated 0.4 cm depth. During telephone interview on 09/17/20 at 4:33 PM, Nurse, Staff A was asked about missing documentation for Resident #2's heel boots, off-loading heels, turning and repositioning every 2 hours in bed, and checking heels when she cared for Resident #2 on the day shift of 08/20/20. Staff A remembered Resident #2 and stated firmly that she did not have any wounds, that she checked her heels because sometimes she complains her leg bothers her and told her there was nothing, and that she definitely did not do wound care for her because she didn't have any wounds. Staff A also stated Resident #2 did not have any heel boots. Staff A stated the CNAs (Certified Nurse Assistants) are supposed to turn the resident every 2 hours but are not always able to because it depends if they are short staffed, that sometimes the CNAs are short. During telephone interview on 09/18/20 at 6:33 PM with Nurse, Staff B who took care of Resident #2 and documented her skin was intact on 08/31/20, Staff B remembered Resident #2 and stated she checked her skin but she did not have any wound, that upon her last assessment she had redness on her back but no skin breakdown. Staff B specifically denied dressing a wound to her heel and stated there was no wound. Staff B had documented wound care with Dakin's solution on gauze and dry dressing for Resident #2's right heel and that she had checked her heel status for deterioration on the evening of 08/31/20. A Change in Condition form on 09/1/20 at 0030 documented Resident #2 was febrile with axillary (armpit) temperature of 101.2 and a respiratory rate of 24 (normal is not above 20). A Nurse Progress Note, effective date 09/01/20 at 7:45 PM documented Resident #2 had swelling of her right foot with warmth to the heel and surrounding area for which she was started on antibiotic for infection, new wound treatment orders with an antibiotic solution, and a wound culture ordered. A hospital transfer form documents Resident #2 was sent to the hospital for lethargy, fatigue, poor oral intake, and elevated temperature on 09/02/20.
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**

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 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Based on record review and interview, the facility failed to ensure 1 of 3 residents (Resident #2) received accurate weekly nurse skin assessments for wounds, dressing changes per orders, and other interventions ordered including turning/repositioning, to check heels every shift, and to apply protective heel boots daily to prevent worsening of a right heel pressure ulcer; or to transfer Resident #2 to the hospital promptly when ordered on [DATE]. These combined failures contributed to Resident #2's pressure ulcer becoming infected with signs [MEDICAL CONDITION], for which she required hospitalization and referral to surgery for [REDACTED]. The findings included: The facility's Policy and Procedure titled Skin Evaluation, effective date 11/30/14, revised 04/01/17, documents the Policy: a Licensed Nurse will complete a total body evaluation of each resident weekly, and prior to a hospital or other facility transfer/discharge, paying particular attention to any skin tears, bruises, stasis ulcers, rashes, pressure injury, [MEDICAL CONDITION], abrasions, reddened areas and skin problems; and under Procedure: 1. a Licensed Nurse will complete a total body evaluation on each resident weekly and document the observation on the Skin Evaluation Form, and 3. If a resident is assessed as having a skin problem the evaluating nurse will initiate the appropriate form. For pressure areas complete the Pressure Injury Record, and 5. The Licensed Nurse will document the observations on the Skin evaluation form. Resident #2 resided in the facility and was most recently re-admitted on [DATE]. Resident #2's MDS (Minimum Data Set) Assessment with target date of 08/10/20 documents she had [DIAGNOSES REDACTED]. Her Brief Interview for Mental Status (BIMS) score was 13, indicating she was cognitively intact. Resident #2's Consulate Weekly Skin Integrity Review dated 07/31/20 at 11:10 AM documented a black area to the right heel measuring 8 cm (centimeters) by 6 cm. Resident #2's Pressure Ulcer Wound Rounds dated 07/31/20 at 1:00 PM documented a suspected Deep Tissue Injury (DTI) to the right heel, type as pressure, measuring 8.0 x 6.0 cm. The National Pressure Injury Advisory Panel (accessed at https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf) defines a Deep Tissue Pressure Injury as persistent non-blanchable deep red, maroon or purple discoloration, intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or [MEDICATION NAME] separation revealing a dark wound bed or blood filled blister. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. Resident #2's Care Plan revisions for potential for pressure injury development and 8/2/20 DTI to right and left heel date initiated 12/08/18 and revised 08/03/20, document under Interventions/Tasks: Apply Multipodus boots bilaterally as ordered to improve skin integrity, initiated 05/09/19; Multipodus boots as ordered, initiated 08/03/20; administer treatments as ordered and monitor for effectiveness, initiated 12/08/18; the resident needs assistance to turn/reposition at least every 2 hours, more often as needed or requested, initiated 12/08/18; and weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate, initiated 12/08/18. A clinician order dated 07/31/20 documents to cleanse the right heel with NSS (normal saline solution), pat dry, paint with [MEDICATION NAME], cover with 4x4 gauze and wrap with kerlix daily. Clinician orders dated 07/31/20 also documented to check heel status every shift and notify MD (medical doctor) for any deterioration, and to apply soft off-loading heel boot every shift every day. An outside wound consultant's Evaluation and Management Report by an Advanced Registered Nurse Practitioner for date of service 08/03/20 documents Resident #2 had a new unstageable pressure wound to the right heel with black necrotic tissue in the wound bed. The National Pressure Injury Advisory Panel defines an Unstageable Pressure Ulcer as an obscured full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Resident #2's Pressure Ulcer Wound Rounds by nursing staff with effective date 08/03/20 at 5:41 PM document Resident #2 had an unstageable right heel pressure ulcer that measured 7.0 x 6.8 x 0.3 cm (centimeters) with black eschar in the wound bed, no drainage and no odor. A clinician order dated 08/03/20 documents to change wound care orders for the right heel to use normal saline, apply [MEDICATION NAME], and cover with dry dressing every other day and as needed. Previous wound care orders were for skin prep to the heel daily Resident #2's MDS Assessment of 08/10/20 also documents she had 1 unstageable pressure ulcer with suspected deep tissue injury in evolution that was not present on reentry and interventions included turning and repositioning program and pressure ulcer care. Pressure Ulcer Wound Rounds with effective date 08/10/20 at 12:10 PM document Resident #2 had an unstageable right heel pressure ulcer that measured 7.0 x 6.8 x 0.3 cm with black eschar in the wound bed, no drainage and no odor. The next staff nurse assessment of Resident #2's wound was documented on 08/24/20. There was no evidence of a weekly nursing skin and/or wound assessment for 08/17/20, and no nursing documentation of description or measurements of the right heel ulcer between 08/10/20 and 08/24/20. The only evidence of wound assessment between these dates was documentation by the wound consultant Nurse Practitioner who visited the resident in the facility on 08/17/20. Resident #2's next Consulate Weekly Skin Integrity Review with effective date 08/24/20 did not indicate any wounds on an anatomic diagram, indicated yes for skin intact, and included a narrative note no new skin impairment noted at this time. Despite indicating skin was intact, the same nurse that conducted this skin assessment also documented completion of 2 different wound treatments to Resident #2's right heel, once with [MEDICATION NAME] and once with the new treatment of [REDACTED]. The wound consultant Nurse Practitioner's visit note for date of treatment 08/24/20 documents Resident #2's right heel wound status was deteriorating with moderate serous (clear, watery) drainage and excessive black and yellow necrotic tissue, measuring 7 x 6 x estimated 0.4 cm depth. Resident #2's clinician orders on 08/24/20 included to obtain consent for bedside debridement (removal of dead tissue with sharp instrument); a vascular consult right heel necrotic; to discontinue current treatment to the right heel; and new wound care orders to cleanse the wound with normal saline, then apply 4x4 gauze moistened with Dakin's full strength (solution), and cover with dry dressing daily and PRN (as needed). Despite the order to discontinue current treatment to the right heel on 8/24/20, Resident #2's August 2020 Treatment Administration Record documented right heel treatments with saline, [MEDICATION NAME], and dry dressing continued to be performed every other day from 8/24 to 8/31, in addition to the new daily wound treatments to right heel with full-strength Dakin's solution. Resident #2's September 2020 Treatment Administration Record documented the (discontinued) right heel treatment with [MEDICATION NAME] was completed but not the currently ordered treatment with Dakin's solution. Review of the Resident #2's August 2020 Treatment Administration Record lacked documentation that orders were followed for (1) heel boots to be applied, (2) heels off-loaded, and (3) heel status checked every shift for deterioration during the day and night shifts on 08/20/20, or on day shifts 08/24/20 and 08/30/20. Review of the Resident #2's August 2020 Treatment Administration Record also lacked documentation that orders were followed to turn and reposition her every 2 hours in bed and every 1 hours in a chair for 9 AM, 11 AM and 1 PM each day on 08/20/20, 08/24/20, and 08/30/20. On 08/27/20, Resident #2 was seen by a vascular consultant. He noted decreased pulses in both lower extremities; and [MEDICAL CONDITION] and a reight heel ulcer to the right lower extremity. Due to contractures, patient not able to tolerate U/S (ultrasound). Recommend angiogram (when able to leave facility). Continue current wound care and medication management. Follow up in 2-3 weeks. Resident #2's Consulate Weekly Skin Integrity Review dated 8/31/20 did not indicate any wounds on the anatomic diagram and indicated yes for skin intact. There was no evidence of documentation of a wound assessment for 08/31/20. However, the wound consultant Nurse Practitioner's visit note for 08/31/20 documents Resident #2's right heel wound had excessive black/yellow necrotic tissue and moderate serous drainage, measured 7 x 6 x estimated 0.4 cm depth, and interventions that included offloading heels, a turning and repositioning schedule, and heel protection. A Change in Condition form on 09/1/20 at 0030 documented Resident #2 was febrile with axillary (armpit) temperature of 101.2 and a respiratory rate of 24 (normal is not above 20). A Nurse Progress Note, effective date 09/01/20 at 7:45 PM documented Resident #2 had swelling of her right foot with warmth to the heel and surrounding area for which she was started on antibiotic for infection, new wound treatment orders with an antibiotic solution, and a wound culture ordered. Resident #2's Order Summary for 08/01/20 to 09/02/20 includes the order Transfer resident out to ER, DX: fever, fatigue, not eating, hyoxic (sic) with order date 9/1, start date 9/1. Order entry detail was requested multiple times from the Administrator but not provided. Resident #2's Treatment Administration Record documented the one-time order to Transfer resident out to ER, DX: fever, fatigue, not eating, hyoxic (sic) had a one-time start date of 09/01/20 at 10:48 PM. A Nurse Progress Note dated 09/02/20 at 07:00 AM documents Resident #2 was awake but nonresponsive and the clinician was called for orders. A second duplicate order Transfer resident out to ER, DX: fever, fatigue, not eating, hyoxic was re-entered (same wording and misspelling) on 09/02/20 with start date 09/02/20. An ARNP/NP/PA (Advanced Registered Nurse Practitioner/Nurse Practitioner/Physician Assistant) Progress Note, effective date 09/02/20 at 8:56 AM, created 09/02/20 at 8:58 documents per nurse (name) pt did not go to the hospital and is listless. 2nd order given for transfer to hospital, and to notify provider if pt does not go. A SNF/NH (Skilled Nursing Facility/Nursing Home) to Hospital Transfer Form, dated 09/02/20 at 9:45 AM documented Resident #2's reasons for transfer as lethargy/ fatigue/poor po intake/elevated temperature [MEDICAL CONDITION] with vital signs that then included an accelerated heart rate of 122 (normal is not over 100) and respiratory

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F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) rate of 24, blood pressure of 161/87. Hospital records document Resident #2 arrived to the hospital on [DATE] at 11:20 AM. Emergency Department Provider Notes dated 09/02/20 at 11:48 AM document she presented with altered mental status and foul-smelling wound along the right heel with diffuse [DIAGNOSES REDACTED] (redness), warmth, and [MEDICAL CONDITION] (swelling) surrounding foot and ankle concerning for osteo[DIAGNOSES REDACTED]/[MEDICAL CONDITION]. The hospital History and Physical dated 09/02/20 at 2:46 PM documents under Assessment/Plan #Sepsis as evidenced by [MEDICAL CONDITION](fast heart rate), leukocytosis (high white blood cell count), and AMS (altered mental status). Right foot wound x-rays suggest gas gangrene and Surgery consulted for possible amputation. During telephone interview on 09/17/20 at 4:33 PM, Nurse, Staff A was asked about missing documentation for Resident #2's heel boots, off-loading heels, turning and repositioning every 2 hours in bed, and checking heels when she cared for Resident #2 on the day shift of 08/20/20. Staff A remembered Resident #2 and stated firmly that she did not have any wounds, that she checked her heels because sometimes she complains her leg bothers her and told her there was nothing, and that she definitely did not do wound care for her because she didn't have any wounds. Staff A also stated Resident #2 did not have any heel boots. Staff A stated the CNAs (Certified Nurse Assistants) are supposed to turn the resident every 2 hours but are not always able to because it depends if they are short staffed, that sometimes the CNAs are short. During telephone interview on 09/17/20 at 2:16 PM, Nurse, Staff C stated nurses may have up to 30 residents each which is too many and most nurses must cut corners. Staff C stated she does not have time to measure wounds and has never seen wound measurements by other nurses. Staff C stated there are not enough CNAs to do everything they are supposed to do and to ensure residents are turned every 2 hours. During telephone interview on 09/18/20 at 6:33 PM with Nurse, Staff B who took care of Resident #2 and documented her skin was intact on 08/31/20, Staff B remembered Resident #2 and stated she checked her skin but she did not have any wound, that upon her last assessment she had redness on her back but no skin breakdown. She specifically denied any wound to her heel. The Treatment Administration Record documents Staff B completed wound care with [MEDICATION NAME] and dry dressing to Resident #2's right heel wound on 08/12/20, 08/14/20, and 08/22/20; and that she checked her heel status and applied her heel boots on the evening shifts of 08/07/20 through 08/09/20, 08/11/20 through 08/14/20, 08/17/20, 08/19/20, 08/22/20, 08/23/20, and 08/31/20. During telephone interview on 09/21/20 at 2:31 PM, the physician responsible for Resident #2 during her stay confirmed the Nurse Practitioner he works with gave an order the evening of 09/01/20 for Resident #2 to be sent to the hospital but she received a call from the facility on 09/02/20 that Resident #2 wasn't doing well and issued a second order to transfer her out, since she had not gone as ordered the night before.
F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure adequate staffing of nurses and CNAs (Certified Nurse Assistants) to provide ordered care and services to residents or to designate a charge nurse on each tour of duty. This affects all residents in the facility and resulted in adverse outcome for 1 of 3 residents (Resident #2) who did not received ordered interventions to prevent worsening of a right heel pressure ulcer (cross reference to F686). The findings included: 1) Resident #2 resided in the facility and was most recently re-admitted on [DATE]. Resident #2's MDS (Minimum Data Set) Assessment with target date of 08/10/20 documents she she did not walk; was dependent on staff for transfers, dressing and toileting; and had a pressure ulcer to the right heel. Resident #2's clinician orders dated 07/31/20 document to cleanse the right heel with NSS (normal saline solution), pat dry, paint with [MEDICATION NAME], cover with 4x4 gauze and wrap with kerlix daily; to check heel status every shift and notify MD (medical doctor) for any deterioration; and to apply soft off-loading heel boot every shift every day. Resident #2's clinician orders on 08/24/20 included to discontinue current treatment to the right heel; and new wound care orders to cleanse the wound with normal saline, then apply 4x4 gauze moistened with Dakins full strength (solution), and cover with dry dressing daily and PRN (as needed). Resident #2's Care Plan area for potential for pressure injury development and 8/2/20 DTI to right and left heel initiated 12/08/18 and revised 08/03/20, documents under Interventions/Tasks: Multipodus boots as ordered; administer treatments as ordered and monitor for effectiveness; the resident needs assistance to turn/reposition at least every 2 hours, more often as needed or requested; and weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate, initiated 12/08/18. Record review revealed Resident #2 had no wound or skin assessment between the dates of 08/10/20 and 08/24/20, and that the skin assessment of 08/24/20 indicated her skin was intact. A wound consultant's visit note for 08/24/20 documented the continued presence of an unstageable pressure ulcer the the left heel. Despite indicating skin was intact, the same nurse that conducted this skin assessment also documented completion of 2 different wound treatments to Resident #2's right heel, once with [MEDICATION NAME] and once with the new treatment of [REDACTED]. The wound consultant Nurse Practitioner's visit note for 08/31/20 documents Resident #2's right heel wound had excessive black/yellow necrotic tissue and moderate serous drainage, measured 7 x 6 x estimated 0.4 cm depth, and interventions that included offloading heels, a turning and repositioning schedule, and heel protection. During telephone interview on 09/17/20 at 4:33 PM, Nurse, Staff A was asked about missing documentation for Resident #2's heel boots, off-loading heels, turning and repositioning every 2 hours in bed, and checking heels when she cared for Resident #2 on the day shift of 08/20/20. Staff A remembered Resident #2 and stated firmly that she did not have any wounds, that she checked her heels because sometimes she complains her leg bothers her and told her there was nothing, and that she definitely did not do wound care for her because she didn't have any wounds. Staff A also stated Resident #2 did not have any heel boots. Staff A stated the CNAs (Certified Nurse Assistants) are supposed to turn the resident every 2 hours but are not always able to because it depends if they are short staffed, that sometimes the CNAs are short. During telephone interview on 09/18/20 at 6:33 PM with Nurse, Staff B who took care of Resident #2 and documented her skin was intact on 08/31/20, Staff B remembered Resident #2 and stated she checked her skin but she did not have any wound, that upon her last assessment she had redness on her back but no skin breakdown. She specifically denied any wound to her heel. The Treatment Administration Record documents Staff B completed wound care with [MEDICATION NAME] and dry dressing to Resident #2's right heel wound on 08/12/20, 08/14/20, and 08/22/20; and that she checked her heel status and applied her heel boots on the evening shifts of 08/07/20 through 08/09/20, 08/11/20 through 08/14/20, 08/17/20, 08/19/20, 08/22/20, 08/23/20, and 08/31/20. 2) During telephone interview on 09/21/20 at 3:32 PM, the Director of Nursing (DON) stated both that RNs are charge nurses and that all nurses are charge nurses; that for help the CNAs can go to LPNs and RNs and LPNs can go to RNs; and LPNs and RNs can call a Unit Manager or, after hours, the DON if they need help with assessment or evaluation. Review of facility schedules by unit revealed no evidence of designated charge nurses on most evenings or any night shifts. Daily detailed assignment schedules with staff to resident assignments were requested but not provided. 3) During telephone interview on 09/17/20 at 2:16 PM, Nurse, Staff C stated nurses may have up to 30 residents each which is too many and most nurses must cut corners. Staff C stated she does not have time to measure wounds and has never seen wound measurements by other nurses. Staff C stated there are not enough CNAs to do everything they are supposed to do and to ensure residents are turned every 2 hours. Staff C stated no one is in charge at night and that there used to be a supervisor who worked in the evenings and sometimes stayed until 1 or 2 AM, but that person has been out sick for weeks without anyone being in charge. Staff C stated if a resident needs to go to the hospital, it is a time-consuming process for the nurse with no one to help them since everyone has their own assignments, and if they send the person out they will be behind on all of their work. Staff C also reported that when staff call off they are not replaced and often not even taken off the schedule, such that the nurse only learns by who shows up. She stated after call-offs there may be one CNA for 50+ residents or one nurse for a unit with capacity for 60 residents. Staff C says when this happens, staff can't do all that is supposed to be done, residents can't be turned as they should, and they can barely get them cleaned for the next shift. 4) During telephone interview on 09/18/20 at 2:05 PM, Nurse Staff D stated there is not enough staffing to care for residents properly; that 2 nights before there were 2 CNAs who had 26 residents each; that management seems to think CNAs can take care of 25 to 26 residents each but they are total care and incontinent, need to be turned and repositioned, and what happens is they are lying in their feces and urine; that the CNAs do all they can do but there is only so much they can do in 7 1/2 hours. Staff D says it is not physically possible for the CNAs to get to all their residents every 2 hours, as they are supposed to. Staff D states the ones who suffer are the residents, they get pressure ulcers, they end up infected. Staff D said families complain and management tells staff not to tell them the caseload or that they are short staffed, but that is what is causing most of these issues. Staff D stated they must consistently work through breaks, that management tells them to take their breaks,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105495	A. BUILDING _____ B. WING _____	**09/14/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HILLCREST HEALTH CARE AND REHABILITATION CENTER	**4200 WASHINGTON ST HOLLYWOOD, FL 33021**

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 0725 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) but it is not possible with the caseload. Staff D says when there is a deficiency, management tells them what they need to do but never addresses the underlying issue of staffing ratios which is the reason they can't do everything properly. Staff D stated many other staff feel the same way but are afraid to say anything for fear of retaliation. Staff D stated there is no one in charge of evening shifts during the week on any units since the evening supervisor is out sick or in charge on the night shifts on any units. Staff D states there is no time to review CNA documentation for completeness. Staff D stated there can be multiple admissions despite only 2 nurses on a unit with full caseloads and no assistance to do the admissions.