STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105812	A. BUILDING _____ B. WING _____	03/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ROYAL CARE OF AVON PARK	1213 W STRATFORD RD AVON PARK, FL 33825

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 observation, interview and record review, the facility failed to assess and treat skin conditions for two residents (#72 and #39) of three sampled residents. Findings included: 1. During observation and interview with Resident #72 on 3/10/20 at 1:41 p.m. the resident was observed with scabs all over his face. The resident stated he is unsure of what the scabs are from or how long he had them. During an interview on 3/12/20 at 4:17 p.m. with Staff F, Licensed Practical Nurse (LPN) she stated he has ointment on his bedside table the daughter brings him for his extremely dry skin and [MEDICATION NAME] for his ear. She confirmed he had scabs all over his face and some newer ones around his mouth. Staff F, LPN lifted the covers and looked at his feet after removing his soft boots. Both heels were free of wounds, the right foot had black scabs on top of four toes where the sheets would rub on the foot. Staff F, LPN stated the wound care nurse would take care of those. During an interview on 3/12/20 at 4:52 p.m. with Staff M, Certified Nursing Assistant (CNA) he stated the resident usually has scabs on his face but has not given him a bed bath or put lotion on today. Staff M, CNA said he did not tell the nurse about the scabs. Staff M, CNA stated he had not looked at the resident's toes. During an interview on 3/12/20 at 6:25 p.m. with the Administrator, she stated she went down to evaluate the resident and saw that his toes have scabs on the right foot and she agreed that there should be some documentation related to his skin condition, a care plan related to his skin condition and some lotion for his dry skin. The Administrator confirmed his daughter brings in lotion to put on his body and we did not have an order for [REDACTED]. Bilat Feet/Heels: Apply Skin Prep Daily as [MEDICATION NAME] TX Once a Day; 05:00 AM - 07:00 PM started 9/4//19 - open ended. Review of the resident's care plan updated on 3/12/20 reflected the resident receiving treatment for [REDACTED]. Review of the Skin/Weekly note and Skin - Weekly Nurses Note and Skin Check, revealed: 3/6/20 reflected a scab to the right side of the neck and no other open areas. 2/28/20 reflected no open areas. Review of the nursing progress notes dated 3/12/20 at 4:31 p.m. reflected Resident #72 evaluated and noted to have dark red spots to forehead and side of face. Dermatology consult in place. Review of the nursing progress notes dated 3/1/20 reflected the resident with redness and irritation to his abdominal folds, area cleaned with normal saline, barrier cream for comfort. Call out to physician. Review of the nursing progress notes dated 2/26/20 at 11:09 a.m. reflected the right side of the resident's neck underneath his ear is swollen and hanging with a scab. Review of the nursing progress notes dated 2/26/20 at 2:03 p.m. reflected the physician called back and ordered ointment to right side of ear and face. start [MEDICATION NAME] 100 mg twice a day for 21 days. During an interview with the Director of Nursing (DON) on 3/13/20 at 4:21 p.m. she confirmed that she was not aware of the scabs on Resident #72's toes. 2. Record review of the face sheet revealed Resident #39 had [DIAGNOSES REDACTED]. On 3/10/20 at 11:00 a.m. Resident #39 was observed in her room lying in bed, watching TV (Television). In an interview she stated, I have something like a big paper cut on my thigh from the mechanical lift happen in the last two weeks. They lifted me and I said I felt some pulling in my thigh. They checked but said they didn't see anything. Then in a couple of days they saw it and called the wound doctor. Now they provide care for it. Review of the physician order report dated 3/12/20 - 3/12/20 revealed there were no active orders physician orders for wound care. an order for [REDACTED]. An additional review of the active care plan on 3/11/20 revealed a problem start date of 3/11/20 for, Res. (Resident #39) receiving TX (treatment) to Bilat (bilateral) Inner Thighs. Review of Skin/Weekly note and Skin -- Weekly Nurses note and Skin Check, assessments reflected the following information: 3/8/20 at 07:08 PM under weekly skin audit: No open areas. 3/2/20 at 09:23 AM revealed under weekly skin audit: No open areas. 2/22/20 at 01:00 AM revealed under weekly skin audit: No open areas. A nursing progress note dated 3/06/2020 at 12:55 a.m. stated, Resident inner rt (right) thigh has an old skin tear that has reopened. Cream barrier applied. Will let wound nurse know in the morning. Further review of progress notes from the month of February 2020 revealed a Wound Care note from [DATE] at 12:54 AM stating, Res (resident) noted with areas of irritation red in color to bilat(bilateral) posterior thighs areas noted to be areas of irritation caused by (mechanical lift) pad. MD notified and treatment orders in place per MD. Staff educated on placing a sheet between res. And Mechanical pad prior to transfers to aid in skin impairments. Review of the Minimum Data Set (MDS) Quarterly assessment dated [DATE] revealed: Section M Skin Conditions - Risk of pressure ulcer/injuries: YES Other ulcers, wounds and skin problems: coded NONE OF THE ABOVE. Section G: Functional Status- Activities of daily living (ADL) Assistance. Transfer: Total dependence, Two + person assist On 3/11/20 at 10:26 a.m. an interview with Staff F, Licensed Practical Nurse (LPN) confirmed there were no orders for skin treatment for [REDACTED]. On 3/11/20 at 2:30 p.m. an observation was conducted with Staff A, Certified Nursing Assistant, (CNA) during a skin check. Staff A, CNA entered Resident #39's room and asked for Resident #39's consent to observe the skin tear on Resident #39's right inner thigh. Staff A, CNA asked Resident #39, This was with the Mechanical lift, right? Resident #39 answered, Yeah, they know. Resident #39 confirmed this happened about a week ago. A 3-inch thin curved red line was observed on Resident #39's right inner thigh, partially covered with a white substance. An interview was conducted on 3/11/20 at 2:53 p.m. with Staff N, Wound Care Nurse. The Staff N stated that when a CNA observes something, they report it to the nurse. The nurse then verifies, observes, documents and calls the doctor for orders. Staff N reviewed the skin observation notes for 3/8/20 at 7:08 p.m. and confirmed the documentation indicated no open areas. Staff N was not aware of the injury until today. Staff N said, I went to see her. The resident was on the phone at the time. Staff N reviewed the nurse's note from 3/6/20 and confirmed it indicated a skin tear in right inner thigh. Staff N said it happened on Friday going on Saturday. The weekend wound care nurse gets in later in the day. If she was informed, she would have treated the area. The nurse on the shift should have called the doctor or reported it. An interview was conducted with the Assistant Director of Nursing, (ADON) on 3/12/20 at 8:36 a.m. She stated, Yes, I was aware that the resident had stated it was with the (mechanical) lift. The ADON then stated, . I'm not aware of the skin tear from 3/8/20. I know about an excoriation. Barrier cream is applied on that general area when resident is being assisted with perineal care. The process is for the nurse to write up an incident, and then we follow up with an investigation. An interview was conducted with Staff B, LPN on 3/12/20 at 9:05 a.m. Staff B, LPN said, She had a red line, and he pointed to his right inner thigh. There was no opening. I guess I should of used another word, like maybe excoriation. I should have called the doctor, and I failed to do that. I left a note for the wound nurse. Usually the wound nurse comes early, so I left a note on her computer. She must have come later that day. Review of the policy titled, Pressure Ulcer and Skin Assessments, L III revised September 2013, revealed the following: Section: Assessments 2. Skin Assessments. Skin will be assessed for the presence of developing pressure ulcers on a weekly basis and more frequently if indicated. 3.b. Nurse are to be notified to inspect the skin if the skin changes are identified. c. Nurse will conduct skin assessments at least weekly to identify changes. Section: Identifying Residents at Risk: b. Shear- shearing force is the sliding movement of skin and subcutaneous tissue while the underling

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 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) muscle and bone are stationary. d. Friction- the rubbing of one body against another or the force that relative motion between two bodies in contact and or material elements sliding against each other. Section: Steps in the Procedure: 4. Once inspection of skin is completed proceed to the admission assessment or weekly skin integrity tool (depending on whether this is a new admission or and existing resident) and complete documentation of findings. 5. If a new skin alteration is noted, initiate (pressure or non-pressure) form related to the type of alteration in the skin. 6. Proceed to care planning and interventions individualized for the resident and their particular risk factor 7. Notification (refer to below reporting) 8. Document the procedure. Section: Documentation: The following information should be recorded in the resident's medical record utilizing facility forms: 1. The type of assessment conducted 2. The time and date of skin care provided. 4. Any changes in the residents' condition. 5. the condition of the resident skin 7. Any problems or complaints made by the resident related to the procedure. 13. Documentation in the medical record addressing MD notification if new skin alteration noted with change of plan of care if indicated. 14. Documentation in the medical record addressing family, guardian or resident notification if new skin alteration noted with change of plan of care if indicated. Section: Reporting 3. notification of attending MD if new skin alteration noted. 4.notification of family, guardian or resident update is new skin alteration noted. Review of the policy titled, Wound Care, Level III revised September 2017, reflected the following information: Documentation: The following information should be recorded in the resident's medical record. 1. The type of wound care given 3. the date and time the wound care was given. 4. The name and the tile of the individual performing the wound care. 5. any changes in the resident condition.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, interviews, policy review, and the State Agency Surveyor Guidance for Hot Water Temperatures related to the Federal regulations, the facility did not ensure water temperatures were maintained at a safe level for four resident bathrooms of twelve resident bathrooms sampled, and for one nursing unit (300 hallway) of two nursing units, with the potential to affect six residents (#56, #47, #139, #50, #140, #65) of eight residents who were capable of using the bathroom. Findings included: 1. Resident #56 was admitted to the facility with a [DIAGNOSES REDACTED]. The Minimum Data Set (MD) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating Resident #56 was cognitively intact. Further review of the MDS assessment, Section G, Functional Status, indicated Resident #56 required extensive assistance of one person to use the toilet, bathe, and perform personal hygiene activities. Resident #56 also used a walker and wheelchair for mobility with extensive assistance of one person. The assessment showed Resident #56 had an indwelling catheter and was frequently incontinent of bowel. 2. Resident #47 was admitted to the facility with a [DIAGNOSES REDACTED]. A review of the MDS assessment dated [DATE] reflected Resident #47 had a BIMS score of 15, indicating she was cognitively intact. Further review of the assessment revealed Resident #47 required extensive staff assistance for locomotion, bathing and toileting, with the use of a walker or wheelchair. Resident #47 was capable of performing personal hygiene with supervision of one staff member. Section H, Bladder and Bowel, showed Resident #47 was always continent of bladder, and always continent of bowel. On 3/10/20 at 11:52 a.m. an observation was conducted in Resident #56 and Resident #47's shared bathroom. The hot water in the bathroom sink was so hot the surveyor had to pull her hand out. There was steam coming from the water. On 3/10/20 at 12:18 p.m. an observation was conducted with the Director of Maintenance in Resident #47 and Resident #56's bathroom. The Director of Maintenance used a thermometer to assess the temperature of the hot water in the bathroom sink. The thermometer read 115.9 degrees Fahrenheit. An interview with the Director of Maintenance was conducted during the observation. He said he hasn't had a problem with the water temperatures before and, It's a very easy fix. I can just adjust the mixer. On 3/10/20 at 2:19 p.m. an interview was conducted with Staff C, Certified Nursing Assistant (CNA) She said Resident #47 and Resident #56 are both alert and oriented. Staff C, CNA said Resident #56 has a nephrostomy tube and wears a brief. Resident #47 uses the bathroom. 3. Resident #139 was admitted to the facility with a [DIAGNOSES REDACTED]. Review of the Admission Observation dated 3/3/20 for Resident #139 revealed that she was oriented to person, place, and time. Resident #139 had no weakness or musculoskeletal problems and was capable of using a walker for mobility. The observation also indicated Resident #139 was continent of bladder and bowel, and capable of using the bathroom unassisted. 4. Resident #50 was admitted to the facility with a [DIAGNOSES REDACTED]. A review of the MDS assessment in the medical record revealed Resident #50 had a BIMS score of 15, indicating she was cognitively intact. Further review of the assessment reflected that Resident #50 required extensive staff assistance of one person for locomotion using a wheelchair, toileting, and bathing. Resident #50 was capable of performing personal hygiene activities with supervision and set up help only. Section H, bladder and bowel reflected Resident #50 was occasionally incontinent of bladder, and frequently incontinent of bowel. On 3/10/20 at 11:59 a.m. an observation was conducted in the shared bathroom for Resident #50 and Resident #139. The hot water in the bathroom sink was too hot for the surveyor to keep her hand under the running water. There was also steam noted to be coming from the faucet. On 3/10/20 at 12:15 p.m. an observation was conducted with the Director of Maintenance. The Director of Maintenance placed a thermometer under the running water in the bathroom sink in the bathroom shared by Residents #50 and #139. The thermometer read 116 degrees Fahrenheit. In an interview with the Director of Maintenance during the observation he said the temperature are running a little high. They are not supposed to be less than 105 degrees and not over 115 degrees. He said the facility has a mixer in the laundry room that feeds the new section of the building. He said he checks the mixer daily. He said he does not keep a log. 5. Resident #140 was admitted to the facility with a [DIAGNOSES REDACTED]. Review of the MDS assessment dated [DATE], in the medical record reflected a BIMS score of 15, indicating Resident #140 was cognitively intact. A review of Section G Functional Status in the MDS assessment revealed Resident #140 needed extensive assistive of one person with use of a walker or wheelchair for mobility. Resident #140 also needed extensive assistance of one staff member to use the toilet and bathe. He required supervision of one person to carry out personal hygiene activities. Section H Bladder/Bowel - Catheter, Ostomy, Incontinence of the MDS assessment was also reviewed and indicated Resident #140 was continent of bladder and bowel. An observation was conducted on 3/10/20 at 12:02 p.m. in Resident #140's bathroom. The hot water in the bathroom sink was so hot the surveyor had to pull her hand out of it. There was steam coming from the water. On 3/10/20 at 12:09 p.m. an observation was conducted with the Director of Maintenance. The Director of Maintenance used a thermometer to check the hot water temperature in Resident #140's bathroom sink. The thermometer was noted to peak at 115.9 degrees Fahrenheit. In an interview conducted at the time of the observation, the Director of Maintenance said the 300 nursing unit has been open since the end of January. All the inspections were done, and everything was 100%. He said the water is checked monthly. We go to the rooms and check the temperature in the sink and the shower in every room. He also said once a month they do a full room inspection and check everything. When residents are discharged , they do a room inspection again. On 3/10/20 at 2:21 p.m. an interview was conducted with Staff D, Licensed Practical Nurse (LPN). She said Resident #140 uses the bathroom and he is alert and oriented. His roommate doesn't use the bathroom. He wears a brief. 6. Resident #65 was admitted to the facility with a [DIAGNOSES REDACTED]. A review of the MDS assessment in the medical record dated 2/20/20 revealed a BIMS score of 9, indicating cognitive impairment. Further review of the MDS assessment reflected that Resident #65 required extensive assistance of one person for locomotion with a walker or wheelchair. Resident #65 required extensive assistance of one person for toileting and bathing, and supervision of one person for personal hygiene activities. Section H Bladder/Bowel - Catheter, Ostomy, Incontinence showed Resident #65 was occasionally incontinent of bladder, and frequently incontinent of bowel. An immediate audit of the 300 halls was requested. The audit showed that the hot water temperature in Resident #65's bathroom sink was 115.9 degrees Fahrenheit on 3/10/20 at 1:17 p.m. On 3/10/20 at 12:23 p.m. an observation was conducted of the mixer in the laundry room, with the Director of Maintenance. The mixer was located above the water heater on the wall. The reading on the hot water heater read 112 degrees Fahrenheit. The mixer temperature gauge on the water line above the hot water heater was set to 100 degrees Fahrenheit. On 3/10/20 at 12:35 p.m. an interview was conducted with the Director of Maintenance. He said he was going to reset the mixer and if it continues to be an issue, they will put a new mixer under all the sinks. He said he should be able to drop the temperature a quarter and that should fix the problem. It will probably take 45 minutes to reset because it's a big water tank. If it's at a time when we're not doing laundry, it's going to take a minute because the hot water heater is insulated. This mixer is only for this building (referring to the 300 nursing unit). He turned the mixer temperature down, and he also turned the hot water heater down. A review of the policy

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F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) titled, Water Temperatures, Safety of, revised December 2009, reflected the following information: Policy Statement Tap water in the facility shall be kept within a temperature range to prevent scalding of residents. Policy Interpretation and Implementation 1. Water heaters that service resident rooms, bathrooms, common areas, and tub/shower areas shall be set temperatures of no more than 115 degrees Fahrenheit (F)., or the maximum allowable temperature per state regulation. 2. Maintenance staff is responsible for checking thermostats a d temperature controls in the facility and recording these in a maintenance log. 3. Maintenance staff shall conduct periodic tap water temperature checks and record the water temperatures in a safety log. 4. If at any time water temperatures feel excessive to the touch (i.e., hot enough to be painful or cause reddening of the skin after removal of the hand from the water), staff will report this finding to the immediate supervisor. A review of the State Agency surveyor guidance related to the code of Federal regulations for hot water temperatures (https://ahca.myflorida.com/MCHQ/Field_Ops/Protocols/General/Fiels/Hot_Water-Protocol.pdf) showed the following: (page 2-3) The following are some regulatory requirements for hot water temperatures in health care facilities: Nursing home, 42 CFR483.25 only requires that water temperature is safe. 105 degrees Fahrenheit to 115 degrees Fahrenheit. (page 4) High Risk Population for [MEDICAL CONDITION] anyone can be affected by scalds, certain people are at increased risk. These high risk groups include infants and young children, older adults and people with any type of disability. Males are about twice as likely to be scalded as females in all age groups. Older Adults Older adults, like young children, have thinner skin so hot liquids cause [MEDICAL CONDITION] even brief exposure. Their ability to feel heat may be decreased due to certain medical conditions or medications so they may not realize water is too hot until injury has occurred. Older adults may also have conditions that make them more prone to falls in the bathtub or shower or while carrying hot liquids. People with Disabilities or Special Needs Individuals who may have physical, mental, or emotional challenges require some type of assistance from caregivers are at high risk for all types of burn injuries including scalds. The disability may be permanent or temporary due to illness or injury and vary in severity from minor to total dependency on others. Sensory impairments can result in decreased sensation, especially to the hands and feet, so the person may not realize something is too hot. Changes in a person's intellect, perception, memory, judgment or awareness may hinder the person's ability to recognize a dangerous situation (such as a tub filled with scalding water) or respond appropriately to remove his or herself from danger. While the principles of scald prevention that apply to the general population also apply to this high risk group, there are additional concerns that must be addressed. Scald injuries result in considerable pain, prolonged treatment, possible lifelong scarring, and even death. The number of deaths from scalds is 100 annually in all age groups. Tap water scalds are often more severe than cooking related scalds. Nationwide, tap water scalds result in more inpatient hospitalization s, generally cover a larger percent of the person's body, and result in more fatalities than other types of scalds.
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 interview and record review, the facility failed to effectively monitor bowel elimination and patterns for one resident (#35) of three sampled residents. Findings included: A review of the Face Sheet for Resident #35 revealed and admission date of [DATE] and that the resident was receiving hospice services. [DIAGNOSES REDACTED]. An alert was documented as refusal of treatment waiver, no intubation, no ventilation, no CPR, no tube feeding, no daily, weekly, or monthly weights. A review of Resident #35's Vital Results recording in the medical record from [DATE] to [DATE] reflected the resident's bowel movements (BM) from [DATE] to [DATE] as None. Further review of the Vital Results recording showed: -[DATE] a small bowel movement was documented at 2:03 p.m. -[DATE] at 2:57 a.m. reflected a small bowel movement and at 2:21 p.m. reflected a small bowel movement -[DATE] at 12:10 a.m. a bowel movement of none/120 ml (milliliter) was documented and at 2:45 p.m. a medium bowel movement was reflected -[DATE] at 1:48 p.m. a small bowel movement/ 0 ml was documented and at 11:37 p.m. a bowel movement of none/120 ml documented -[DATE] at 11:48 p.m. a bowel movement of none/120 ml was documented -[DATE], [DATE], [DATE], [DATE] bowel movements were recorded as none -[DATE] at 11:42 p.m. a bowel movement of none/120 ml documented During an interview on [DATE] at 6:24 p.m. with Staff E, Licensed Practical Nurse (LPN) stated the Certified Nursing Assistant (CNA) documents on a form (Vital Signs Recording) then the nurse transfers the bowel movements to a Bowel Protocol form. Staff E, LPN confirmed the Bowel Protocol form was not completed from [DATE] to [DATE] and stated she was unaware of when Resident #35 last had a bowel movement as the documentation was not completed. Staff E stated she had not completed her documentation for the day ([DATE]) and retrieved the Vital Signs Recording form to track Resident #35's bowel movements. After the documentation was completed, Staff E confirmed the resident's last bowel movement was [DATE] and stated she was not aware of this. Staff E stated they were told to document on these forms and if they are not updated then it is hard to track the bowel movements and will look at Resident #35's bowel protocol. During an interview on [DATE] at 6:25 p.m. with the Director of Nursing (DON), she confirmed the CNAs document on the Vital Signs document for bowel movements and the nurse transfers them to the BM form (Bowel Protocol Form). During an interview on [DATE] at 8:30 a.m. with the Hospice Nurse, she confirmed the resident does not eat much and may not have a bowel movement every day. The Medical Director walked up at that time and stated she does not eat much and is on hospice, but her belly is soft, and he would not expect daily bowel movements as she eats around 25%. During an interview on [DATE] at 11:44 a.m. after providing a bowel movement timeline completed by the Administrator to track Resident #35's bowel movements. The DON stated Resident #35 had a BM on [DATE] and reconfirmed the Administrator completed the BM timeline form. The DON stated the hospice nurse was called and asked when Resident #35 last had a BM. The DON provided documentation that the nurse was contacted on [DATE] at 9:43 a.m. The DON stated the resident had a BM on [DATE] that was not documented so they added it today. The DON and Assistant Director of Nursing (ADON) stated, hospice aides will tell the nurse and the nurse should document the BM. The DON and ADON stated the nurses look at the vital signs document and transfers the BMs to the BM protocol paper to know when the residents last had a bowel movement. The DON stated that document should have been filled out daily. During an interview on [DATE] at 12:14 p.m. with the Administrator stated that she completed the timeline to show Resident #35's bowel movements. The Administrator stated the nurses should be looking at the CNA flow sheet to see when the resident last had a BM. The Administrator stated that she did not know what the bowel protocol document was and had not seen it before. The Administrator stated that the nurses should be documenting on the computer and from now on they will be using the computer to document all vital signs, BM and intake. The DON walked in and the Administrator asked why the nurses are not using the computer to document BMs. The DON stated that she has the nurse fill out the BMs on the paper form and stated they will be using the computer for documentation from now on. The DON stated that the facility does not have a bowel protocol. A review of the policy titled, Bowel Management, undated, revealed: Monitoring of Bowel Movements -Nurses on the evening shift are responsible for monitoring resident's bowel by checking logs and or reports -Residents who have not had a bowel movement in three days will be assessed for constipation and treated accordingly per physician orders [REDACTED].#9007, revised ,[DATE], reflected: The provision of nursing care is based on the resident's care plan and shall be documented in the resident's medical record. The facility will perform admission and random audits on medical records to ensure accuracy and compliance. The resident's medical record shall include the following nursing documentation: -Nursing care provided, as reflected in the interdisciplinary care plan -Resident response to nursing care -Evaluation of nursing care . -Resident's current status -Changes in resident's physical or behavioral condition, including symptoms -A summary of the resident's condition, to include the extent nursing goals are achieved. .Nurse managers shall use admission checklist and audit tools for chart audits, any missing/incorrect documentation shall be addressed through education.
F 0760 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one [MEDICAL TREATMENT] resident (#10), of three sampled [MEDICAL TREATMENT] residents, was free from a significant medication error by failing to obtain and dispense a [MEDICAL TREATMENT] medication from January 17, 2020 to March 13, 2020. Findings included: A review of the Face Sheet for Resident #10 revealed that she was admitted on [DATE] with [DIAGNOSES REDACTED]. On 3/11/20 at 5:06 p.m. during an interview with the Resident #10, she confirmed she received [MEDICAL TREATMENT] and she stated that she does not get medication while at [MEDICAL TREATMENT]. Review of the physician progress notes [REDACTED]. It reflected the [MEDICAL CONDITION] hormone level was 1096 and the phosphorus level on 2/4/20 was 6.3. The intervention reflected [MEDICATION NAME] 60 mg (milligrams) once a day. A fax sheet from the [MEDICAL TREATMENT] center noted to give [MEDICATION NAME] 60 mg once a

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F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) day. A handwritten note on the fax sheet reflected, Already on since 1/17/20, and [MEDICATION NAME] 800 mg tabs three times a day with meals, was documented as, Done. This document was faxed from the [MEDICAL TREATMENT] center on 2/25/20 at 2:09 p.m. Review of the prescription order dated 1/17/20 reflected the medication ([MEDICATION NAME] 60 mg once a day) was ordered on [DATE] at 6:36 a.m. and a new order faxed to the pharmacy dated 3/13/20 at 11:23 a.m. The medication ordered ([MEDICATION NAME]/[MEDICATION NAME]) treats [MEDICAL CONDITION] due to kidney failure. Review of the nursing progress notes dated 1/17/20 at 7:38 a.m. by Staff I, Unit Manager (UM) reflected, Received new orders for [MEDICATION NAME] 60 mg daily from nephrologist at [MEDICAL TREATMENT] center, resident was currently taking 30 mg and new orders to increase to 60 mg, Medical Director agrees and new orders put into computer. Review of the nursing progress notes dated 1/28/20 at 5:32 p.m. by Staff J, Licensed Practical Nurse (LPN) reflected, medication [MEDICATION NAME] has not been available. call made to pharmacy multiple days in a row. Pharmacy stated the first time called that they needed a signature from unit manager to sign for medication. Medication was signed and faxed to pharmacy. Medication was still not sent the next day. 1/27/20 the nurse called pharmacy again and pharmacist stated that they have a note from billing company that resident's insurance isn't paying for it and [MEDICAL TREATMENT] center is. We are supposed to get medication from [MEDICAL TREATMENT] center. Call made to [MEDICAL TREATMENT] center and they are unsure if they send medication to a facility but do sent it home with patients. Night nurse informed of situation and to pass information on to day nurse. Review of the Medication Administration Record [REDACTED]. Review of the MAR indicated [REDACTED]. - 1/23/20 at 5:39 p.m. reflected, call to pharmacy, said script needed to be signed by unit manager to send medications. - 1/27/20 at 5:05 p.m. reflected, call to pharmacy, said it will be on next run. - 1/28/20 at 5:32 p.m. call made to pharmacy and [MEDICAL TREATMENT]. - 2/5/20 at 5:44 p.m. reflected, call made to pharmacy, stated manager needed to sign waiver to approve to be sent due to cost. - [DATE] at 6:31 p.m. reflected, call made to pharmacy stated she will fax waiver to pharmacy direct for unit manager and DON (Director of Nursing) to sign. Review of the MAR for 1/24/20, 1/29/20, 2/1/20, 2/2/20, 2/3/20, 2/4/20, 2/10/20, 2/11/20, 2/12/20, 2/15/20 reflected [MEDICATION NAME] was unavailable. Further review of the MAR for February 2020 revealed: - 2/16/20 documented by Staff J, LPN reflected, call to pharmacy, stated they would fax over waiver to sign by unit manager or DON. - 2/18/20 documented by Staff K, LPN reflected resident refused medication. - 2/19/20 and 2/20/20 reflected item was unavailable. - 2/23/20 reflected, sent reorder to pharmacy. - [DATE] to 2/28/20 reflected item was unavailable. Further review of the MAR for March 2020 revealed: - 3/1/20 reflected item unavailable - 3/2/20 reflected resident refused related to upset stomach - 3/3/20 reflected administered on time by Staff K, LPN. - 3/4/20 and 3/5/20 reflected the item was unavailable. - 3/6/20 reflected the medication was given on time by Staff L, LPN. - 3/7/20 to 3/13/20 reflected item was unavailable. Review of the nursing progress notes dated [DATE] at 12:43 p.m. documented by Staff I, UM reflected the labs and orders were received from the [MEDICAL TREATMENT] center. Review of the nursing progress notes dated 3/10/20 at 3:09 p.m. documented by Staff I, UM reflected medication was reviewed by the Advanced Registered Nurse Practitioner (ARNP) and new orders were added to the computer. During an interview on 3/13/20 at 12:26 p.m. with the ARNP she stated staff told her the resident was refusing [MEDICATION NAME] and the nephrologist was advised that the resident was refusing the medication. The ARNP was unaware the medication was not available since 1/17/20 and stated the facility was telling her the resident was refusing the medication and she had no idea the medication was not ordered. During an interview on 3/13/20 at 12:22 p.m. with the Medical Director, he stated it was concerning that her [MEDICAL CONDITION] level is going up and was told the resident was refusing her medication. The Medical Director stated he would have referred her to her nephrologist if he knew her levels were continuing to rise. He confirmed he was not aware the facility did not obtain and dispense the medication. He was informed that she was refusing the medication and at one point suggested hospice. During an interview on 3/13/20 at 11:23 a.m. with Staff I, UM he stated if a medication is not available the physician should be notified after the first dose was missed. During an interview with Staff G, LPN UM on 3/13/20 at 10:39 a.m., she stated that she did not have the [MEDICATION NAME] in her cart this morning and reordered the medication. She stated the resident (Resident #10) was out to [MEDICAL TREATMENT] yesterday so she was not supposed to give it to her then and was unaware yesterday it was not in the cart but did order the medication and showed the steps she took to order the medication on the computer. During a phone interview on 3/13/20 at 12:34 p.m. the Consultant Pharmacist stated she was unaware the medication was documented as unavailable since January 17, 2020. She could see it was ordered, but not sent or billed to the facility and stated she would find out and call back. She stated she reviewed her medications but did not see that the medication was unavailable all of that time. During an interview on 3/13/20 at 12:50 p.m. with the DON and ADON. The DON stated the medication was unavailable and the resident should have received the medication at [MEDICAL TREATMENT]. The DON stated we knew the resident was refusing medications at times but never noticed that the medication was marked unavailable since January 17th (2020) with the exception of two nurses documenting they gave the medication once or twice. The ADON stated if a nurse had an issue obtaining medication the situation should have been escalated. The ADON stated we look at orders daily, random charts. The ADON stated Staff I, UM reviews the [MEDICAL TREATMENT] residents. He would be the one to contact the nephrologist if we had an issue. Staff I, UM joined them at this time. During the same interview, the DON, ADON and Staff I were asked how they could determine if all of the residents were receiving medication as ordered. The DON stated, nurses, the pharmacist and others look at the records on a daily basis. The DON could not answer why Resident #10 did not receive [MEDICATION NAME] starting January 17th and no one noticed, but the one nurse that documented she was trying to obtain the medication. The DON repeated she only knew the resident had a history of [REDACTED]. Staff I, UM stated the pharmacy never contacted him regarding [MEDICATION NAME] and he was unaware it was not ordered. During an interview on 3/13/20 at 2:29 p.m., the DON confirmed all of the residents in the building were receiving medications as ordered except Resident #10. During a phone interview on 3/13/20 at 2:32 p.m. with Staff K, LPN, he stated he gave Resident #10, two 30 mg tablets of [MEDICATION NAME] on 3/3/20 at 7:43 p.m. Staff K, LPN was asked where he obtained the medication since the resident had not received any other doses from 1/17/20. Staff K, LPN did not answer. During a phone interview on 3/13/20 at 2:35 p.m. with Staff J, LPN stated she spoke to the pharmacy and [MEDICAL TREATMENT] multiple times. The pharmacy stated insurance does not approve. [MEDICAL TREATMENT] stated the medication cannot be dispensed to the resident if in a nursing home. She called back and spoke to the manager and they gave a one time a dose while the resident was at [MEDICAL TREATMENT]. Staff J, LPN called the pharmacy and they said they would send the medication if the document was signed by the manager. They said they would send a seven day supply. Then the pharmacy said they would have billing send a document to Staff I, UM's phone since that is how he received information from the pharmacy. Staff I, UM was asked several times if he received a fax and stated he never did, but stated he gets the information on his phone. Staff I, UM stated again he had not received anything on his phone. Staff J, LPN stated she spoke to [MEDICAL TREATMENT] many times. Staff J, LPN confirmed the DON and Staff I, UM knew Resident #10 was not receiving the medication. Review of the care plan reflected an evaluation date of 3/13/20, revised on 3/13/20 at 10:09 a.m. by the Social Service Director for a problem area with a start date of 12/13/19 that the resident will self-determine not to take medications. Approach start date 12/13/19 reflected to notify the primary care physician and responsible party of changes/self determination to not participate with care. Review of the care plan evaluation notes dated 12/11/19, last revised on 3/10/20, reflected a problem area at risk for hypertension, failure to thrive, end stage [MEDICAL CONDITION]. An Approach, dated 6/22/19, included labs/meds (medications) per order. Review of the Facility Order Audit (matrix), undated, reflected: [MEDICAL TREATMENT] resident's med (medication) times are checked for times, orders for site care and management are present and fluid restrictions if applicable are documented correctly with alerts in (electronic medical record). Review of the policy and procedure titled, Medical Record Documentation Audit Reference #9007, revised 11/2017, reflected: the provision of nursing care is based on the resident's care plan and shall be documented in the resident's medical record. The facility will perform admission and random audits on medical records to ensure accuracy and compliance. The resident's medical record shall include the following nursing documentation: Nursing care provided, as reflected in the interdisciplinary care plan, medications administered and any untoward reactions. Review of the policy related to routine nursing documentation audit, undated, reflected two pages: Orders - Complete orders so they are transmitted to the pharmacy to be filled ASAP (as soon as possible). Progress notes should be used on all residents when needed to explain what is going on with the resident i.e. labs, order changes, appointments. Review of the policy for the consultant pharmacist IIIA1, 143 to 145: dated April 2017 reflected: D. In performing medication regiment reviews, the consultant pharmacist incorporates federally mandated standards of care. E. The consultant pharmacist identifies irregularities through a variety of sources including medication administration records (MARS), prescriber orders; progress notes of prescribers, nurses and or consultants; 5) Laboratory results, diagnostic studies, or other medication therapy measurements are obtained by staff/prescriber and are acted upon. Review of the policy IIIB2: Medication Management dated April 2017, pages 151 to 154 reflected: In order to optimize the therapeutic benefit of medication therapy and minimize or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105812	A. BUILDING _____ B. WING _____	03/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ROYAL CARE OF AVON PARK	1213 W STRATFORD RD AVON PARK, FL 33825

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F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) prevent potential adverse consequences, facility staff, the attending physician/ prescriber, and the consultant pharmacist perform ongoing monitoring for appropriate, effective, and safe medication use. When selecting medications and non-pharmacological interventions, members of the interdisciplinary team participate in the care process to identify assess, address, advocate for and monitor the residents needs and changes in condition. Review of the policy and procedure IIIB3:preventing and detecting adverse consequences and medication errors reflected: The facility employs a system to assure that medication usage is evaluated on an ongoing basis. Significant medication related problems are assessed, documented and reported as appropriate to the resident's attending physician. F. In the event of a significant medication-related or adverse consequence, immediate action is taken, as necessary, to protect the resident's safety and welfare. Significant is defined as 3. Requiring treatment with a prescription medication.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview the facility failed to ensure safe and secure storage and labeling of medications related to 1. high-risk medications were stored at the resident bedside for one resident (#192) of a total sample of 31 residents, 2. one medication cart (Northwest) and one treatment cart (300-hall) were unlocked while unattended, 3. eye drops were stored with oral medications in two medication carts(Southwest and Northwest) of four medication carts, and 4. high risk medications stored in an unlabeled bag in one medication room of two medication rooms. Findings included: 1. On 3/10/20 at 1:05 p.m., two pre-filled syringes were observed in plastic packaging lying on an over-the-bed table of Resident #192. The resident was sitting in a wheelchair with the table in front of the wheelchair and the syringes were within reach of the resident. Staff D, Licensed Practical Nurse (LPN), confirmed the pre-filled syringe with a yellow cap was [MEDICATION NAME] and the white capped syringe was normal saline. The staff member stated [MEDICATION NAME] syringes were not stored at the bedside, they are kept in the medication room and, it must be left over from last night. (Photographic Evidence Obtained) 2. At 1:47 p.m. on 3/10/20, an observation on the 300-hall revealed a treatment cart which contained prescribed topical medications was in front of the nursing station, unlocked and unattended. Staff D, LPN was observed walking past the cart with a glass of water. The Assistant Director of Nursing (ADON) came from the hallway and noticed the treatment cart was unlocked. The ADON confirmed the treatment cart was unlocked and unattended. (Photographic Evidence Obtained) 3. On 3/11/20 at 4:20 p.m., the Southwest (SW) medication cart was observed with Staff E, LPN. The observation revealed a bottle of Tums and a box of [MEDICATION NAME] was stored in the same undivided area as eye drops. The staff member stated eye drops should not be stored with oral medications. At 4:29 p.m. on 3/11/20, the Northwest (NW) medication cart was observed with Staff E, LPN. The observation indicated a box of [MEDICATION NAME] in the same undivided area as eye drops in the top drawer. On 3/12/20 at 4:50 p.m., an observation of the Northeast medication cart was conducted with Staff F, LPN. The observation revealed a box of [MEDICATION NAME] eye drops was stored in between bottles of oral over-the-counter medications. The staff member confirmed different routes of medications should not be stored together. (Photographic Evidence Obtained) 4. On 3/11/20 at 4:43 p.m., an observation of the West medication preparation room with Staff E, LPN, revealed a plastic bag with an assortment of pre-filled syringes in a drawer that also contained influenza testing swabs and dressing change kits. The plastic bag contained four pre-filled syringes with 5 milliliters of [MEDICATION NAME] and two syringes with 10 milliliters of normal saline. The bag was unlabeled and did not indicate which resident was prescribed the [MEDICATION NAME]. (Photographic Evidence Obtained) The policy titled, Medication Storage in the Facility, dated April 2018, indicated medications and biologicals are stored safely, securely, properly, and following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. The policy identified the following: - medication rooms, carts, and medication supplies are locked when not attended by persons with authorized access. - all medications dispensed by the pharmacy are stored in the container with the pharmacy label. - orally administered medications are kept separate from externally used medications and treatments such as suppositories, ointments, creams, vaginal products, and etc. Eye medications are stored separately per facility policy. - Controlled substances that require refrigeration are stored within a locked box within the refrigerator and the box must be attached to the inside of the refrigerator. An interview was conducted, on 3/13/20 at 9:52 a.m., with the Consultant Pharmacist. The Consultant Pharmacist confirmed that medication carts were to be locked when unattended and oral medications are to be stored separate from eye drops. The Consultant Pharmacist stated bags of pre-filled medication syringes need to have a label on the bag identifying the medication and the prescribed resident.
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 observations, interviews, and record review the facility did not ensure appropriate infection prevention measures were maintained related to maintaining a nasal cannula, oxygen tubing, a [DEVICE] and [DEVICE] off the floor for one resident (#140) of two residents reviewed for infections. Findings included: Resident #140 was admitted to the facility with a [DIAGNOSES REDACTED]. A review of Resident #140's Physician order [REDACTED]. May apply N.S. (normal saline) wet to dry dressing prn (as needed) if unable to get machine to function properly. [DATE] O2 (oxygen) at 2L (liters) via nc (nasal cannula) continuous to keep O2 sats >90% (saturation greater than 90 percent). On 3/10/20 at 2:07 p.m. an observation was conducted of Resident #140 in his bed, and the tubing from the wound vac was resting on the floor on the resident's left side of the bed. The wound vac was in a blue bag sitting on the floor on the resident's left side of the bed. The oxygen tubing was attached to the concentrator on the resident's right side of the bed. The tubing and nasal cannula were also sitting on the floor of the resident's right side next to the bed. On 3/11/20 at 3:22 p.m. an observation was conducted of Resident #140 lying on his bed on his back. He was clean and dressed and without odor. His wife was at the bedside visiting. The nasal cannula was on the floor on the resident's right side of the bed. The wound vac with the tubing were also observed on the floor on the resident's left side of the bed. On 3/11/20 at 3:24 p.m. an interview was conducted with Staff C, Certified Nursing Assistant (CNA). Staff C confirmed the wound vac and tubing were on the floor. She also confirmed the oxygen tubing was on the floor. She said she didn't even know he had a wound vac. Staff C, CNA also said they weren't supposed to be on the floor. She removed the wound vac from the floor and put it on Resident #140's bed. She picked up the nasal cannula and placed it in a bag on the bed side table. She exited the room and went into the supply room and brought a new nasal cannula with tubing to the room. A review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating Resident #140 was cognitively intact. A review of Section G Functional Status of the MDS assessment revealed Resident #140 needed extensive assistive of one person with use of a walker or wheelchair for mobility. Resident #140 also needed extensive assistance of one staff member to use the toilet and bathe. He required supervision of one person to carry out personal hygiene activities. On 3/12/20 at 9:23 a.m. an interview was conducted with Resident #140's family member. The ADON (assistant director of nursing) was present during the interview. The family member of Resident #140 reported that Resident #140 wears continuous oxygen and that Resident #140 told her he had taken it off to go the bathroom. The family member also said Resident #140 told her that he put the wound vac (vacuum) on the floor when he came back from the bathroom. She said he already knew he wasn't supposed to put the wound vac and oxygen tubing on the floor. The ADON said he has been educated not to put the oxygen tubing or wound vac on the floor. A review of Resident #140's current care plan dated [DATE] revealed a care plan had not been created regarding Resident #140's removal of his nasal cannula or placing the wound vac on the floor, until 3/11/20. On 3/12/20 at 4:45 p.m. an interview was conducted with the ADON. She said residents remove their oxygen and put tubing on the floor and the facility educates them and they still do it. Staff can't be in their rooms all the time. A review of the policy titled, Infection Control, revised on July 2014, documented the policy statement as, This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections.