STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105466	A. BUILDING _____ B. WING _____	**05/22/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE OF PALM BEACH	**4405 LAKEWOOD ROAD LAKE WORTH, FL 33461**

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 monitor and follow up on a change of condition in a timely manner for 1 of 3 sampled residents, Resident #2, as evidenced by failing to fully investigate and conduct a timely assessment when Resident #2 experienced facial grimacing and leg swelling. The findings included: Review of the clinical record revealed Resident #2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On 05/21/20 at 3:15 PM, a phone interview was conducted with Staff C, a certified nursing assistant (CNA). The interview revealed that on 04/28/20, Staff C came into the resident's room to feed Resident #2 breakfast. Staff C then bathed her, and noticed her left leg was swollen. She called Staff A, the registered nurse, who assessed the resident and said it's ok. On 04/29/20, Staff C saw that the resident's leg was still swollen. Staff C revealed that she didn't report it again, since it was reported on Tuesday, 04/28/20. On 04/30/20, Staff C saw the leg was still swollen, as she prepared to give the resident a bed bath. She then reported it to a different nurse, a licensed practical nurse (Staff B). A subsequent interview was conducted with Staff C on 05/22/20 at 2:40 PM, in which she reiterated the same statement that she made on the phone. On 05/21/20 at 3:26 PM, an interview with Staff A, the registered nurse (RN), was conducted. Staff A stated that Staff C had called her to check on Resident #2 on 04/28/20, while the resident was in bed on her back. She did not see bruises or swelling. She had no facial grimacing. On 05/21/20 at 3:35 PM, an interview was conducted with Staff B, the licensed practical nurse (LPN). Staff B stated that on 04/30/20 Staff C had called her into Resident #2's room to check the resident. Staff C asked her to check the resident's left leg and it was swollen. She reported that while Staff C was bathing her, she could see the leg was swollen and warm, and Resident #2 made a facial grimace when the area was touched. She further stated that she then called the Nurse Practitioner (NP) to ask her to check the resident when she came to the facility later that day. A phone interview was conducted with the NP on 05/22/20 at 3:55 PM. The NP stated that Staff B had called her on 04/30/20 and asked her to see Resident #2 when she came into the facility later on 04/30/20. She examined the resident's leg and saw swelling and a blue spot on the left leg. She further revealed that the resident was grimacing when she touched the leg. She saw the resident around 7:00 PM and ordered an x-ray of the entire left leg. The NP stated the resident already had a physician order [REDACTED]. She told the nurse to send the resident to the hospital for evaluation since it was a fracture. There is no evidence of nursing documentation for this conversation and no order written to send the resident to the hospital at this time. The NP's note was not in the record and had not been scanned into the computer. The NP did not know what nurse she had spoken to. A request was made to the Director of Nursing (DON) for the progress notes for Resident #2 for the period of 0[DATE] through 05/21/20. A review of these progress notes revealed that the first nursing progress note for this time period was dated 04/28/20 at 0025 hours (00:25 AM) revealing the resident had no pain or discomfort, she is in bed, alert and responsive. On 04/29/20, a social service progress note revealed that family was notified that there was [MEDICAL CONDITION] in the building. On 04/30/20 at 1919 hours (7:19 PM), a nursing progress note revealed that the resident's left leg was noted with 'swelling and was warm to the touch'. The resident 'made grimace when touching'. The Advanced Registered Nurse Practitioner (ARNP) was made aware and had assessed the resident. The ARNP had ordered X-rays of the entire leg; and the Administrator had notified the son. On 05/01/20 at 9:49 AM, a nursing note revealed the results of the X-ray of the left femur were received that documented an acute moderately displaced fracture supracondylar region of distal femur, old left intertrochanteric fracture healed with mild deformity, moderate osteopenia / [MEDICAL CONDITION], doctor and family aware. On 05/01/20 at 1506 hours (3:06 PM), the notes documented the social service director spoke with family regarding fracture. On 05/01/20 at 1620 hours (4:20 PM), the director of nursing's notes revealed the resident was transferred to the hospital for evaluation and treatment, the doctor and family were notified. A review of the Medication Administration Record [REDACTED]. The review revealed the resident did not have an order for [REDACTED].#2 was not administered any medication for pain from 04/27/20 through 05/01/20. The pain scale on the MAR indicated [REDACTED]. The nursing note for 04/30/20 revealed the resident had facial grimacing, which is a non-verbal sign of pain. In the above interview with the NP, regarding her assessment of the resident on 4/30/20, the resident had grimaced when she had touched her leg. On 05/22/20 at 4:00 PM, an interview was conducted with the DON regarding the timeline from the time Staff C had first identified the swelling in the left leg to the time the resident was sent to the hospital. The swelling was identified on 04/28/20 in the morning and the resident was sent to the hospital on [DATE] at 1446 hours (2:46 PM). During this time, the resident had facial grimacing but there was no evident she was provided any pain medication. The DON verified that there was a delay in treatment for [REDACTED]. The nursing staff did not act on an order from the NP to send the resident to the hospital at 4:00 AM on 05/01/20; but instead sent her at 1446 hours (2:46 PM) on 05/01/20, per an additional order of her physician. After reviewing the nursing progress notes, the DON confirmed that there should have been documentation of the assessments that were done by nurses, and nursing documentation of the phone call with the NP in the early morning of 05/01/20.

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.