STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105952	A. BUILDING _____ B. WING _____	06/29/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GRAND OAKS HEALTH AND REHABILITATION CENTER	3001 PALM COAST PARKWAY SE PALM COAST, FL 32137

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff and family interviews, the facility failed to notify the resident representative of a decline in condition for one (Resident #1) of three sampled residents. The findings include: A record review for Resident #1 revealed a [AGE] year-old male admitted on [DATE] for a short-term stay. His [DIAGNOSES REDACTED]. He was alert, oriented and required limited assistance with activities of daily living. A review of the psychologist's note on 6/11/20, revealed a [DIAGNOSES REDACTED]. History of present problem - changes in mood, chief complaint suicidal ideation. Lives by self with girlfriend. Having neck pain and shortness of breath. Collapse led to admission to hospital and need for rehab. Does not believe back pain being addressed, see pain management doctor has dorsal column stimulator pain management his primary concern. Patient not a danger to himself. Recommendation: evaluate pain management to address chronic pain. There was no documentation indicating the family was notified of the change. During an interview with Resident#1's daughter on 6/26/20 at 2:50 p.m., she stated her father was admitted on [DATE]. She lived out of state and spoke to her father on the phone usually daily. He complained of issues with pain medication. She stated she called the facility and left messages for the social worker in order to discuss what was happening. She also left messages for the administrator and director of nursing. None of her calls were returned. When she last spoke to her father on 6/17/20, he was not making sense. She said she was totally frustrated with the lack of follow up on her concerns. She stated she finally called the corporate office with her concerns and e-mailed the administrator with all her concerns. After her call to the corporate office she received a call from the administrator and director of nursing (DON). During an interview with the DON on 6/29/20 at 4:10 p.m., she was asked if she had any communication with the daughter of Resident #1. She stated she spoke to the resident's daughter on 6/17/20 and informed her that he was having a decline in condition. When asked what had changed, she said he was eating very little, complained of stomach pain, nausea, refused medications at times and refused therapy at times due to not feeling well. She was asked when the decline in condition was first noted. She replied that she was made aware when the daughter e-mailed the administrator on 6/17/20. The daughter had outlined her concerns regarding care issues, her father's condition and she was upset that she left numerous messages for staff and her calls were not returned. When asked to describe the facility's policy for returning calls, she said as soon as possible. The DON was asked where the nurses documented changes in condition and notification to physician and family. She stated in the nursing notes. She was asked to review the notes and confirmed the nurses had not documented any change in condition. .
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 observations, interviews and record reviews, the facility failed to ensure sufficient nursing staff at all times to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being for two (Residents #1 and #5) of six sampled residents with the potential to affect all 112 residents. The findings include: 1. On [DATE] at 10:10 a.m., the Administrator provided a copy of the staff on duty today. A review of the daily schedule for [DATE] revealed there were only two nurses scheduled from 7:00 p.m. to 7:00 a.m. for 112 residents with two residents scheduled for admission today. She was asked why nurses were not scheduled for all units. She replied, We are working on filling those shifts for today. She added that they were short of nurses, several had left and one quit today. At 11:00 a.m., the Director of Nursing (DON) was asked if the nurse positions had been filled for the evening shift. She said she was able to fill the shift. The unit manager would work, so there would be three nurses on duty this evening. She stated they had to terminate a nurse last week and one of their nurses called today and quit. She was asked how many nurses were routinely scheduled for 7:00 p.m. - 7:00 a.m. and she said three. When asked how many residents each nurse was assigned, she stated there was one nurse for the isolation unit (22 residents with 2 admissions coming today), and the other 90 residents were divided between the other two nurses. Review of the daily staffing numbers for the last five weeks revealed multiple days that the facility did not meet minimum staffing for the certified nursing assistants (CNAs) and licensed nurses. The following days did not meet minimum staffing of 2.5 hours per day for CNAs: [DATE] 1.73 hr. ,[DATE] 2.35 hr. ,[DATE] 2.02 hr. ,[DATE] 2.07 hr. ,[DATE] 1.82 hr. ,[DATE] 2.29 hr ,[DATE] 1.95 hr. ,[DATE] 2.20 hr. ,[DATE] 1.86 hr. ,[DATE] 1.51 hr. The following days did not meet minimum staffing for licensed nurses of 1.0 hr. per day: ,[DATE] .90 hr. ,[DATE] 0.87 hr. An interview was conducted with the Administrator on [DATE] at 10:30 a.m. regarding staffing at the facility. She was asked why the staffing numbers were so low and what the facility's plan of action to ensure sufficient staffing would be. She stated they lost staff and had been trying to hire more. All staff, including department heads, were helping out by answering call lights. The Director of Nursing (DON), Assistant Director of Nursing(ADON) and the Minimum Data Set (MDS) nurse had all been working shifts to cover the residents' direct-care needs. When asked whether the facility had considered using Agency staff, she said the decision was made at the corporate level not to use Agency staff. When asked how she was ensuring residents were provided adequate care, monitoring and supervision, she replied that the DON, ADON, MDS nurse and ancillary staff were working to cover the facility. When asked who was overseeing the nursing department if the DON and ADON were working shifts to provide direct care, she stated the regional consultant had been coming in to conduct audits to identify issues and was available by phone. The Administrator was asked whether the facility self-imposed a moratorium when staffing numbers were below minimum requirements. She replied no. A review of the census numbers revealed the daily census at the facility continued to increase. From [DATE] to [DATE], the census went from 104 to 112 with two additional admissions scheduled for today (,[DATE]). The Administrator was asked what changes in staffing had been made to meet the high-acuity needs of the new admissions, and she replied that staffing would remain the same. When asked whether the facility took into consideration the extended time it took to don and doff personal protective equipment (PPE) for each of 22 residents in the isolation unit as well as administering medications, treatments, admitting two new residents, answering the phone, contacting physicians, performing and documenting assessments on the two new admissions as well as other residents on the isolation unit with high acuity needs, she stated there were no changes being made in the staffing numbers and confimed that one nurse would be responsible for those tasks. 2. The Administrator was asked whether the facility had filed any one- and five-day federal reports within the last month and she confirmed that there had been. She stated she would provide those reports for review. A review of the five-day report dated [DATE], revealed that during a routine chart audit it was discovered that on [DATE], the assigned nurse for Resident #7 documented she did not have time to give his medications due to staffing issues. No concerns were voiced by the resident. The nurse

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 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) involved was suspended pending investigation. The physician was notified. The Department of Children and Families (DCF) was notified but did not accept the report. A full investigation was initiated. On [DATE] during a random chart audit, it was noted that Employee F, Registered Nurse (RN), documented on [DATE] that she did not have time to give his (Resident #7) medication due to staffing issues. An investigation was completed of medication availability on this nurse's shifts. Resident #7 was not administered the following medications on [DATE] during the 70 a.m. - 7:00 p.m. shift by Employee F: ASA due at 9 am [MEDICATION NAME] 0.25 mg 9 am [MEDICATION NAME] .125 mg 9 am [MEDICATION NAME] 40 mg 9 am [MEDICATION NAME] 20 mg 9 am Zinc sulfate 9 am Carvedilol 25 mg 9 am [MEDICATION NAME] ER at 9 am 5pm Sodium [MEDICATION NAME] 650 mg 9 am 5pm Vit C 500 mg 9 am 5pm Humalog 2 units with meals 8 am 12pm 5pm [MEDICATION NAME] 10 mg 2pm [MEDICATION NAME] 10 mg 2pm Humalog sliding scale 11 am 4pm The physician was notified, vital signs were obtained, the resident's blood sugar at 11:30 p.m. was 196 and no pain was reported. The DON interviewed Employee F on [DATE]. Employee F stated, I was becoming late in passing meds and had been instructed that if a medication was missing, I must locate it elsewhere in the house and did not have time to continue looking elsewhere for medicine without it causing my med pass to become even later. A review of medications given to residents by Employee F on [DATE] and [DATE] revealed that the following residents did not receive their medications: [REDACTED]#10 on [DATE] did not receive the following: ASA 81 mg 9 am B 12 1000 mg 9 am D 3 1000 9 am Nepro 1,8 box 2pm Renal vitamin 0.8 mg 9 am [MEDICATION NAME] 100 mg 9 am [MEDICATION NAME] 10 units 9 am [MEDICATION NAME] aerosol 9 am [MEDICATION NAME] 3 units 8 am 12pm 6pm Protein 30 ml 9 am 1pm 5pm [MEDICATION NAME] sliding scale Resident #1 on [DATE] did not receive the following: [MEDICATION NAME] 200 mg 9 am [MEDICATION NAME] 60 mg 9 am [MEDICATION NAME] HCT 9 am [MEDICATION NAME] 100 mg 9m [MEDICATION NAME] diskus 9 am 5pm [MEDICATION NAME] 100 mg 9 am Eliquis 2.5 mg 9 am 9pm [MEDICATION NAME] 25 mg 9 am 9p [MEDICATION NAME] 75 mg 9 am [MEDICATION NAME] 2 mg 9 am The chart audits were done on ,[DATE] and [DATE]. The results found there were five medications for four residents that were not available for administration and were ordered from the pharmacy. Employee F was terminated on [DATE]. 3. On [DATE] at 3:10 p.m., a call light was on for room [ROOM NUMBER]. There was also an alarm sounding from an IV (intravenous) pump in the same room. At 3:20 p.m. the call light had not been answered and IV pump alarm continued to sound. At 3:30 p.m. no staff had entered room [ROOM NUMBER] to check on the resident yet. At 3:40 p.m., the surveyor knocked on the door and entered room [ROOM NUMBER]. The male resident in bed B (Resident #11) was upset and stated, I have been calling for a half hour. I want someone to shut off the alarm from the IV; it finished a half hour ago. He stated this happened all the time; there was no one around. At this time, the nurse arrived in the resident's room. The resident expressed how upset he was that the alarm had been going off for a half hour. The nurse shut off the alarm and said she would be right back as she needed to flush the line. He was asked if he had voiced his concerns about the time it took for staff to respond to the call light. He said he had, but nothing had been done. He said administration told the residents they were monitoring the call lights to make sure they were answered, but this hadn't worked yet. 4. A review of the grievance logs for the last three months revealed there were 11 resident complaints regarding call lights not answered timely. During an interview with the Administrator on [DATE] at 2:30 p.m., she was asked how grievances regarding call lights were addressed. She said the facility had ongoing monitoring with all department heads assisting with answering call lights. When asked how often the residents were interviewed for feedback to ensure call lights were answered timely, she said random audits were done. 5. On [DATE] at 3:45 p.m., an overhead page was made for the certified nursing assistant (CNA) to answer the call light for room [ROOM NUMBER]. room [ROOM NUMBER] was in the isolation unit. At 3:50 p.m., another page was made for the CNA to answer the call light in room [ROOM NUMBER]. Another page was heard at 3:55 p.m. and another at 4:05 p.m. The staffing on the isolation unit included one nurse and two CNAs. 6. During an observation of personal protective equipment (PPE) supplies at 3:30 p.m. with the Central Supply Coordinator, two-weeks' worth of supplies were observed. The facility was utilizing plastic disposable gowns. Most of the supply carts outside resident rooms on the quarantine unit were empty. During the tour on this unit five call lights were observed going off. There was no staff in sight. The doorbell was also heard ringing for 15 minutes. There was a new admission waiting at the door of the isolation unit. The Central Supply Coordinator answered the door. At 3:50 p.m. while exiting the unit, call lights continued to sound and had still not been answered. A review of the staffing posted with today's schedule revealed two CNAs and one nurse were on duty in the isolation unit. The Central Supply Coordinator stated that sometimes she helped on the floor as well. During an interview with the DON at 4:00 p.m., she confirmed that they were experiencing a staffing shortage. So far there were three nurses working the 7:00 p.m. - 7:00 a.m. shift. She stated that had been the norm since corporate made the decision to stop using Agency staff. She added that one nurse worked on the isolation unit and two nurses worked on the non-isolation units. She added that she had been working as a floor nurse the last three weeks. The DON was asked whether she was aware that resident assessments and nursing notes were not being documented and the ones that were documented did not reflect care and services or residents' changes in condition. She stated that she noted the issue during an audit, but she had not had time to follow up because she had been scheduled to work an assignment providing direct resident care over the last three weeks. 7. A record review for Resident #1 revealed a [AGE] year-old male admitted on [DATE] for a short-term stay. His [DIAGNOSES REDACTED]. He was alert, oriented and required limited assistance with activities of daily living. A review of the psychologist's note on [DATE], revealed a [DIAGNOSES REDACTED]. History of present problem - changes in mood, chief complaint suicidal ideation. Lives by self with girlfriend. Having neck pain and shortness of breath. Collapse led to admission to hospital and need for rehab. Does not believe back pain being addressed, see pain management doctor has dorsal column stimulator pain management his primary concern. Patient not a danger to himself. Recommendation: evaluate pain management to address chronic pain. There was no documentation indicating the family was notified of the change. During an interview with Resident#1's daughter on [DATE] at 2:50 p.m., she stated her father was admitted on [DATE]. She lived out of state and spoke to her father on the phone usually daily. He complained of issues with pain medication. She stated she called the facility and left messages for the social worker in order to discuss what was happening. She also left messages for the administrator and director of nursing. None of her calls were returned. When she last spoke to her father on [DATE], he was not making sense. She said she was totally frustrated with the lack of follow up on her concerns. She stated she finally called the corporate office with her concerns and e-mailed the administrator with all her concerns. After her call to the corporate office she received a call from the administrator and director of nursing (DON). During an interview with the DON on [DATE] at 4:10 p.m., she was asked if she had any communication with the daughter of Resident #1. She stated she spoke to the resident's daughter on [DATE] and informed her that he was having a decline in condition. When asked what had changed, she said he was eating very little, complained of stomach pain, nausea, refused medications at times and refused therapy at times due to not feeling well. She was asked when the decline in condition was first noted. She replied that she was made aware when the daughter e-mailed the administrator on [DATE]. The daughter had outlined her concerns regarding care issues, her father's condition and she was upset that she left numerous messages for staff and her calls were not returned. When asked to describe the facility's policy for returning calls, she said as soon as possible. The DON was asked where the nurses documented changes in condition and notification to physician and family. She stated in the nursing notes. She was asked to review the notes and confirmed the nurses had not documented any change in condition. 8. A record review was conducted for Resident #5, revealing he was admitted in the facility on [DATE]. The hospital discharge history and physical, dated [DATE], revealed the resident had [DIAGNOSES REDACTED]. The resident had [PROCEDURE] on the left leg on [DATE]. Further review of the admission assessment revealed incomplete skin and medication sections. Additionally, there was no documentation of progress/nurses' notes for [DATE] or [DATE]. A progress note dated [DATE] at 10:14 p.m. indicated: While the certified nursing assistant (CNA) was making rounds, found resident lying in bed unresponsive. Code blue was immediately called, Cardiopulmonary Resuscitation (CPR) initiated, 911 called. Family notified 2:47 p.m. Emergency Medical Service (EMS) arrived and took over. At 4:01 p.m., EMS called time of death. During an interview with the Director of nursing (DON) on [DATE] at 4:00 p.m., she confirmed that there was not enough documentation to paint a picture of what was going on with the resident. She added that she had discovered the issue during an audit, but she had not followed up since she had been working as a floor nurse. .
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to ensure it maintained a complete medical record for two (Residents #5 and #1) of six sampled residents. The findings include: 1. A record review was conducted for Resident #5,

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F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) revealing he was admitted in the facility on [DATE]. The hospital discharge history and physical, dated [DATE], revealed the resident had [DIAGNOSES REDACTED]. The resident had [PROCEDURE] on the left leg on [DATE]. Further review of the admission assessment revealed incomplete skin and medication sections. Additionally, there was no documentation of progress/nurses' notes for [DATE] or [DATE]. A progress note dated [DATE] at 10:14 p.m. indicated: While the certified nursing assistant (CNA) was making rounds, found resident lying in bed unresponsive. Code blue was immediately called, Cardiopulmonary Resuscitation (CPR) initiated, 911 called. Family notified 2:47 p.m. Emergency Medical Service (EMS) arrived and took over. At 4:01 p.m., EMS called time of death. During an interview with the Director of nursing (DON) on [DATE] at 4:00 p.m., she confirmed that there was not enough documentation to paint a picture of what was going on with the resident. She added that she had discovered the issue during an audit, but she had not followed up since she had been working as a floor nurse. 2. A record review for Resident #1 revealed a [AGE] year-old male admitted on [DATE] for a short-term stay. His [DIAGNOSES REDACTED]. He was alert, oriented and required limited assistance with activities of daily living. A review of the psychologist's note on [DATE], revealed a [DIAGNOSES REDACTED]. History of present problem - changes in mood, chief complaint suicidal ideation. Lives by self with girlfriend. Having neck pain and shortness of breath. Collapse led to admission to hospital and need for rehab. Does not believe back pain being addressed, see pain management doctor has dorsal column stimulator pain management his primary concern. Patient not a danger to himself. Recommendation: evaluate pain management to address chronic pain. There was no documentation indicating the family was notified of the change. During an interview with Resident#1's daughter on [DATE] at 2:50 p.m., she stated her father was admitted on [DATE]. She lived out of state and spoke to her father on the phone usually daily. He complained of issues with pain medication. She stated she called the facility and left messages for the social worker in order to discuss what was happening. She also left messages for the administrator and director of nursing. None of her calls were returned. When she last spoke to her father on [DATE], he was not making sense. She said she was totally frustrated with the lack of follow up on her concerns. She stated she finally called the corporate office with her concerns and e-mailed the administrator with all her concerns. After her call to the corporate office she received a call from the administrator and director of nursing (DON). During an interview with the DON on [DATE] at 4:10 p.m., she was asked if she had any communication with the daughter of Resident #1. She stated she spoke to the resident's daughter on [DATE] and informed her that he was having a decline in condition. When asked what had changed, she said he was eating very little, complained of stomach pain, nausea, refused medications at times and refused therapy at times due to not feeling well. She was asked when the decline in condition was first noted. She replied that she was made aware when the daughter e-mailed the administrator on [DATE]. The daughter had outlined her concerns regarding care issues, her father's condition and she was upset that she left numerous messages for staff and her calls were not returned. When asked to describe the facility's policy for returning calls, she said as soon as possible. The DON was asked where the nurses documented changes in condition and notification to physician and family. She stated in the nursing notes. She was asked to review the notes and confirmed the nurses had not documented any change in condition. .