STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105430	A. BUILDING _____ B. WING _____	08/21/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
REHABILITATION CENTER OF WINTER PARK, THE	1700 MONROE AVE MAITLAND, FL 32751

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 0684 **Level of harm -** Immediate jeopardy **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 provide care and services for a central line intravenous catheter (IV) catheter, for 1 of 3 residents reviewed for IV access site out of a total sample of 5 residents, (#1). These failures placed resident #1 at risk for serious injury/impairment/death. Without appropriate central line catheter care, there was high likelihood resident #1 could have developed severe infection, blood clots or bled to death. Resident#1 was admitted to the facility on [DATE] from the hospital where she received IV antibiotic therapy for osteo[DIAGNOSES REDACTED], and infection in her bone. During her 13-week stay in the facility, resident #1 did not receive any care or services for her central line IV catheter. Approximately two months after resident #1 was discharged home, her daughter noticed the central line dangling from the resident's chest. Resident #1 was admitted to the hospital for two days to have the central line removed. The facility's failure to obtain appropriate admission orders [REDACTED]. The Immediate Jeopardy was identified on 8/21/20. The Immediate Jeopardy was removed on 8/14/20. Findings: Resident #1, a [AGE] year-old, female was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On 8/12/20 at 3:12 PM, during a telephone interview with resident#1's daughter, she stated her mother was discharged from the facility with a central line. She stated the family was unaware that the resident had a central line and were not given orders on how to care for the line when the resident was discharged . The daughter stated the line was in for approximately two months after she was discharged home from the facility. She called the facility for guidance and was told to take her mother to the hospital to have it removed since her mother was no longer a resident of the facility. A central line is . a tube that doctors place in a large vein in the neck, chest, groin or arm to give fluids, blood, or medication A lumen is an access channel to the catheter. (Retrieved from Centers for Disease Control and Prevention (CDC) website at www.CDC.gov, accessed on 8/24/20). A review of the facility's Care of Central Venous Catheters .not dated read, Change central line catheter site dressing every week transparent dressing (or as ordered by physician). Change central line catheter site dressing Q (every) 48 hours with gauze dressing (or as ordered by physician). Review of the hospital transfer form, AHCA Form 5000-3008 dated 11/06/19 revealed resident #1 had IV access Type: R chest tunneled cath-double lumen. The hospital History and Physical printed 11/03/19 revealed resident #1 had a central line to her right chest. The Admission Nursing Data Collection form completed on 11/06/19 at 5:00 PM by Registered Nurse (RN) A indicated resident #1 had a central line catheter to her right upper chest. Review of resident #1's medical record revealed Registered Nurse (RN) A did not obtain physician orders [REDACTED].#1's central line on admission. Review of the Licensed Nurse Weekly Skin Observation (Weekly Skin Checks) revealed only 9 of 13 scheduled skin evaluations were done. None of the skin evaluation forms included documentation of resident #1's central line. On 8/20/20 at 12:25 PM, the Minimum Data Set (MDS)/Care Plan Coordinator stated when a resident is admitted to the facility she reviewed the orders, the hospital history and physical and the hospital transfer form. She explained she greeted the resident in person but did not do an assessment. She said, I do not take off their clothes so I would not have seen the IV. The MDS Coordinator explained she developed the basic care plan and the Unit Managers (UM)s and nurses updated them. She said, I am not sure why the IV was missed . I did the best I can. The MDS Coordinator acknowledged her review of the residents and their care needs were based on chart review only. On 8/20/20 at 12:40 PM, the UM stated every newly admitted resident's chart needed to be reviewed within 24-48 hours. She stated chart review was conducted by 3 UMs and the Director of Nursing (DON) who ensured all the safety nets or essential components for care, were in place, such as fall risk assessments, code status and diets. The UM stated the Admission Nursing Data Collection form was not reviewed as part of the safety net process. The UM explained the admitting nurse should start the baseline care plan and other nurses would add to it. The UM recalled reviewing resident #1's chart with the DON and 2 other UMs to include the hospital history and physical and transfer form which had documentation of resident #1's central line. She said, I honestly don't know how 4 of us missed it. The UM stated her expectation was that nurses should communicate information on IV's in shift report and also document on weekly skin checks. On 8/20/20 at 4:00 PM and 4:52 PM, RN A confirmed he completed resident #1's admission assessment. He recalled she had a central line located in the right upper chest near her collar bone, with 2 lumens about 3-4 inches long. RN A explained he called the physician to verify the hospital discharge orders and informed the physician there were no orders for the central line. RN A told the physician resident #1 stated her central line had not been used for a long time. He recalled the physician said, ok but gave no orders. RN A stated it was strange and unusual not to receive orders for central line care. RN A suggested that other team members including the physician, Assistant Director of Nursing (ADON) and assigned nurses who assessed and evaluated resident #1 during her stay in the facility should also have noted the presence of the central line and absence of orders and a care plan. He said, Nurses do weekly skin checks . Any nurse would have seen the line and should have documented it was there. Review of Licensed Nurse Weekly Skin Observation (Weekly Skin Check forms) revealed RN A completed skin checks on resident #1 on 12/05/19 and 12/18/19 with no documentation regarding her central line. RN A stated the rehab UM and other nursing administration staff reviewed charts on the day after admission and should have caught that there were no orders or care plan for resident #1's central line. RN A explained the admitting nurse was responsible for creating the baseline care plan, which was necessary to address the immediate needs of newly admitted residents. On review of the baseline care plan with RN A he confirmed there was no documentation of the central line and stated he did not recognize the signature. RN A acknowledged he did not create the document. On 8/21/20 at 9:25 AM, the DON stated the baseline care plan should be started on admission by the admission nurse. She explained other nurses, the UMs and herself sometimes assisted with this document when the admitting nurse was busy. She confirmed although she initiated and signed resident #1's baseline care plan, she did not actually assess resident #1 or do the skin check. She stated her expectation was that the admitting nurse would continue to work on the document during that shift. The DON stated the chart review process on the day following admission was a team effort. She acknowledged there was a breakdown in the chart review process as the admission assessment and information received from the hospital on admission clearly showed a central line. The DON could not explain how the wound nurse and assigned nurses did skin evaluations and did not identify or document the central line. I would have to agree the skin sweep was not done thoroughly. There is no policy for a skin check prior to discharge so the central line was not noted at that time either. The DON stated the resident was at the facility for, Three months here, two months at home. I am thankful that nothing happened to her. She could have gone septic, developed a severe infection. A central line deposits anything straight into her heart. On 8/21/20 at 11:06 AM, the administrator recalled a telephone call to the facility from resident #1's daughter, about 6 to 8 weeks after her discharge home in February 2020. He said, Someone called about an IV line being left in. I asked if they followed up with the doctor and recommended they take the issue to a doctor. The administrator stated he did not report the daughter's concern to anyone, and the DON confirmed she was never

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 -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) informed of the telephone call. He stated he did not report it to anyone because the daughter did not emphasize the central line as a real concern. She was more focused on getting more medications. Review of the hospital History and Physical dated 4/27/20 revealed resident #1 was admitted for removal of the central line. The document indicated resident #1 had a right upper chest central line that was placed in October 2019 and used for IV antibiotic until November 2019. The note read, This has been in place for a total of 7 months . The line was removed under the supervision of a radiologist and resident#1 remained in the hospital overnight for observation. The facility's corporate Nurse Consultant (NC) stated she was unaware of any incidents related to central lines prior to notification by the State survey agency staff on 8/12/20. The NC explained she initiated an investigation of residents who were admitted to the facility with central lines and discovered documentation of a central line on resident #1's admission data collection sheet. The NC stated the facility held an ad hoc Quality Assurance and Performance Improvement (QAPI) committee meeting on 8/14/20 and developed a Performance Improvement Plan (PIP). Review of the Performance Improvement Plan Worksheet for IV Management revealed the facility identified the problem as Intravenous access orders not all in place and nurses were documenting in the wrong location in the chart. The PIP indicated the contributing factor was nurses were unsure of specific orders for IVs. The facility identified the root causes of the incident as Multiple new nurses (and) Education on processes. The NC explained during her investigation she did not find any orders for or documentation of central line care and management in any section of resident #1's medical record. In addition, the NC confirmed the admission nurse was not new to the facility and was knowledgeable of order input processes. The NC acknowledged the facility's PIP for central line management was not accurate because the root cause analysis did not drill down to the exact areas of breakdown or correctly identify the contributing factors. Therefore, the current PIP did not adequately address all the actions necessary to prevent reoccurrence of the incident. Review of corrective measures implemented on 8/14/20 by the facility revealed the following: Newly admitted residents will have a head-to-toe skin assessment done by 2 nurses, the wound care nurse and a UM. Education for all nurses began on 8/13/20 and will be-ongoing until 100% compliance is achieved. The topics included IV management and entry of batch orders. Staff will not be allowed to work until training has been received. Newly hired nurses will receive the education in orientation. Interviews were conducted with 7 nurses on 8/20/20 between 12:24 PM and 4:52 PM. RN A and LPN B,C,D,E,F, and G were knowledgeable about the process for obtaining admission orders [REDACTED]. Review of staff in-service attendance sheets revealed 96% of nurses had been educated. Nurses who were educated on the phone will have in-person follow-up with the DON or Staff Development Coordinator. Additional education topics for nurses will include performance and documentation of thorough weekly skin sweeps, and initiation of the baseline care plan with a revised form. The QAA committee will review audits of the interventions and re-educate and/or correct processes as needed. The audit tool included presence of IV lines, appropriate care plan and orders in place and skin checks. The sample was expanded to include 2 additional discharged residents and all current residents with IV access sites. Record reviews conducted revealed no concerns related to residents #2, 3, 4 & 5.