STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105460	A. BUILDING _____ B. WING _____	**07/20/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NORTH FLORIDA REHABILITATION AND SPECIALTY CARE	**6700 NW 10TH PLACE GAINESVILLE, FL 32605**

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 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 interview, the facility failed to ensure resident representatives were notified of a change in the resident's status for 1 of 3 sampled residents, Resident #2. Findings: Review of the facility medical records for Resident #2 revealed she was an [AGE] year-old female with [DIAGNOSES REDACTED]. Review of the Medical Certification for Nursing Facility/Home and Community-Based Services Form (Agency for Health Care Administration (AHCA) Form 3008) for Resident #2 from the receiving hospital dated 07/06/2020 revealed stage 4 decubitus ulcer on the sacrum under skin care. No other wounds were documented. Review of the nursing admission assessment for Resident #2 dated 07/06/2020 read, Skin: G tube (Gastrostomy Tube). General skin condition was documented as dry with no concerns on feet. Review of the weekly skin integrity documentation for Resident #2 dated 07/08/2020 read, Sacrum: Pressure wound; R (Right) lower leg front pressure wound. No other weekly skin integrity reviews were documented in the facility medical records. Review of the wound evaluation and management for Resident #2 dated 07/13/2020 read, Focused wound exam (Site #1): Wound of right dorsal foot: wound size: 3.5 x 2 x unmeasurable cm (Centimeters), surface area: 7.00 cm, exudate (Fluid that leaks out of body tissues): light serous, thick adherent devitalized necrotic tissue 100%. Focused wound exam (Site #2): Unstageable DTI (Deep Tissue Injury) of the right lateral heel, wound size: 4 cm x 5 cm x unstageable, surface area: 20 cm. Focused wound exam (Site #3): Unstageable DTI of right lateral foot, wound size: 3 cm x 3 cm x unmeasurable, surface area: 9.00 cm. Focused wound exam (Site #4): Stage 4 pressure wound sacrum, 7.5 cm x 5.5 cm x unmeasurable, 41.25 cm, exudate: heavy serous, 75% thick adherent black necrotic tissue. Review of the nursing progress notes for Resident #2 from 07/06/2020 through 07/20/2020 revealed no documentation of the resident representative having been notified of the resident's change of condition, the development of pressure ulcers. During an interview on 07/20/2020 at 10:07 AM, Staff F, Licensed Practical Nurse (LPN) stated, We complete a change of condition form with any new skin breakdown. When we find any newly developed skin issues, we notify the doctor and notify the family. During an interview on 07/20/2020 at 11:45 AM, Staff G, LPN, stated, I was not aware that (Resident #2's name) did not have any pressure wounds documented on her July readmission nursing assessment. We did not do a complete skin assessment, or it is not accurate. We did not complete a weekly skin sweep and document the results. We did not notify the family of the new wounds found on the resident and we should have. During an interview on 07/20/2020 at 1:35 PM, the ADON (Assistant Director of Nursing) stated, (Resident #2's name) came back from the hospital with a wound on her sacrum. I'm not sure why we did not complete the admission assessment correctly or why weekly skin sweeps were not being documented. It seems like we did not notify the family of the additional wounds that were on (Resident #2's name). we should have documented them, and we should have completed a change of condition form and notified the family. Review of the facility policy and procedures titled Notification of Change in Condition, Document #N-105, last revised on 09/21/2017, read, Policy: to promptly notify the Patient/Resident, the attending physician, and the resident's representative when there is a change in the status or condition. Procedure: The nurse to notify the attending physician and the resident representative when there is a: Significant change in the patients/residents' physical, mental or psychosocial status. The nurse to complete an evaluation of the patient/resident. Document evaluation in the medical record. Notify the patient/resident and the resident representative of the change in condition. Document notification in the medical record.
F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interview, the facility failed to ensure 2 of 3 sampled residents, Residents #1 and #2, received care, consistent with professional standards of practice, to prevent the development or worsening of pressure ulcers. Findings: Review of the facility medical records for Resident #1 revealed that she was an [AGE] year-old female with [DIAGNOSES REDACTED]. Review of physician orders for Resident #1 dated 01/16/2018 read, Weekly skin sweeps. Review of Resident #1's care plan dated 05/29/2020 read, (Resident #1's name) has potential for pressure injury related to bladder and bowel incontinence, impaired mobility and fragile skin. Interventions included skin assessments as ordered. Review of the weekly skin integrity documentation for Resident #1 dated 06/09/2020 read, No new open areas. Dated: 07/5/2020 read, Coccyx: Four (4) open areas on buttock. There was no additional documentation of weekly skin integrity records for the period of 06/10/2020 to 07/04/2020. Review of the wound care evaluation and management summary for Resident #1 dated 07/06/2020 read, Focused wound exam (Site 1): Unstageable DTI (Deep Tissue Injury), etiology: pressure, wound size: 6 cm (centimeters) x 5 cm x unmeasurable, wound surface area: 30.00 cm, light serous exudate (Fluid that leaks out of body tissues). Review of the facility medical records for Resident #2 revealed she was an [AGE] year-old female with [DIAGNOSES REDACTED]. Review of the nursing admission assessment fir Resident #2 dated 07/06/2020 read, Skin: G tube (Gastrostomy Tube). General skin condition was documented as dry with no concerns on feet. Review of physician orders for Resident #2 dated 07/06/2020 read, Weekly skin sweeps. Review of the weekly skin integrity documentation for Resident #2 dated 07/08/2020 read, Sacrum: Pressure wound; R (Right) lower leg front pressure wound. No other weekly skin integrity reviews were documented in the facility medical records. Review of the wound evaluation and management for Resident #2 dated 07/13/2020 read, Focused wound exam (Site #1): Wound of right dorsal foot: wound size: 3.5 x 2 x unmeasurable cm (Centimeters), surface area: 7.00 cm, exudate (Fluid that leaks out of body tissues): light serous, thick adherent devitalized necrotic tissue 100%. Focused wound exam (Site #2): Unstageable DTI (Deep Tissue Injury) of the right lateral heel, wound size: 4 cm x 5 cm x unstageable, surface area: 20 cm. Focused wound exam (Site #3): Unstageable DTI of right lateral foot, wound size: 3 cm x 3 cm x unmeasurable, surface area: 9.00 cm. Focused wound exam (Site #4): Stage 4 pressure wound sacrum, 7.5 cm x 5.5 cm x unmeasurable, 41.25 cm, exudate: heavy serous, 75% thick adherent black necrotic tissue. During an interview on 07/20/2020 at 10:07 AM, Staff F, Licensed Practical Nurse (LPN) stated, We do weekly skin assessments on all residents and document them on the weekly skin assessment form. There would not be any reason we would not complete a skin sweep weekly, they are ordered by a physician, not completing them is not following a physician order and may lead to not finding new skin issues. During an interview on 07/20/2020 at 11:45 AM, Staff G, LPN, stated, I was not aware that (Resident #1's name) did not get weekly skin sweeps as ordered, she should have. It is our policy to do weekly skin sweeps on all residents and document them on the skin assessment forms. We should be checking skin weekly per doctor's orders. Not completing weekly skin sweeps could lead to new skin concerns not being recognized. I was not aware that (Resident #2's name) did not have any pressure wounds documented on her July readmission nursing assessment. We did not do a complete skin assessment, or it is not accurate. We did not complete a weekly skin sweep and document the results. During an interview on 07/20/2020 at 1:35 PM, the ADON (Assistant Director of Nursing) stated, I can't tell you why (Resident #1's name) did not get any skin sweeps or assessment between 06/10/2020 and 07/05/2020 when four areas were found on her coccyx.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) Once we found the areas, we began treatment immediately and had the wound care doctor see the wounds and treatment began. I'm not sure why we did not complete weekly skin sweeps. They did not follow doctor's orders or our policies and procedures for weekly skin sweeps. I'm not sure why (Resident #1 name) did not have a nursing assessment completed when she got readmitted until two days after her readmission. (Resident #2's name) came back from the hospital with a wound on her sacrum. I'm not sure why we did not complete the admission assessment correctly or why weekly skin sweeps were not being documented. It seems like we did not notify the family of the additional wounds that were on (Resident #2's name). We should have documented them, and we should have completed a change of condition form and notified the family. Review of the facility policy and procedures titled Skin Evaluation WC-190, revision date 04/01/2017 read, A licensed nurse will complete a total body evaluation on each resident weekly. 1. A licensed nurse will complete a total body evaluation on each resident weekly and document the observation on the skin evaluation form.
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 observation, interview and record review, the facility failed to perform wound care in a safe and sanitary manner to prevent the potential for infection for 1 of 3 sampled residents, Resident #1. Findings: Review of the facility medical records for Resident #1 revealed that she was an [AGE] year-old female with [DIAGNOSES REDACTED]. An observation of wound care was conducted for Resident #1 on 07/20/2020 beginning at 1:45 PM. Staff F, Licensed Practical Nurse (LPN) assembled all supplies to provide wound care and entered the room. Staff F, LPN, did not perform hand hygiene prior to donning (putting on) gloves. She removed the cap from a bottle of normal saline. When she was unable to remove the protective liner on the top of the normal saline, she removed a pen from her pocket and inserted the pen into the liner puncturing it with the pen, moving the pen around the neck of the bottle, and then removed the protective layer with her gloved hand. Staff F, LPN, assisted the resident to a position on her side. The resident had on an adult brief which Staff F, LPN, removed. There was no dressing on the sacral wound. The brief had a large amount of serosanguinous (a thin watery pinkish yellow discharge) drainage in the area the wound was located. When Staff F, LPN, removed the brief, she placed it in a clear plastic bag. Staff F, LPN, did not remove gloves after removing soiled brief and did not perform hand hygiene. She poured normal saline from the container that was previously opened onto two 4 x 4 gauze and cleansed the sacral wound and placed a large foam dressing over the wound bed covering the resident's rectum. Staff F, LPN, lifted up the dressing to reposition it and placed the area which had come in contact with the rectum directly over the wound. The staff was observed placing the soiled gauze and normal saline bottle in the clear plastic bag containing the soiled brief, which was on the resident's bed. Staff F, LPN, removed her gloves and donned a new pair. She did not perform hand hygiene. Staff F, LPN, removed Resident #1's heel protective boot to reveal a right DTI (deep tissue injury) on the side of the resident's right foot near the little toe. Staff F, LPN, proceeded to remove the normal saline bottle out of the bag, which contained the soiled brief and used wound dressing supplies, she cleansed the area and applied skin prep. Staff F, LPN, proceeded to remove the left heel protective boot, cleansed the left heel DTI with normal saline from the bottle that had been removed from the bag to moisten gauze, and applied skin prep to the area. Staff F, LPN, did not change her gloves or perform hand hygiene between completing the wound care to Resident #1's feet. During an interview on 07/20/2020 at 2:10 PM, Staff F, LPN, stated, I did not wash my hands or use hand sanitizer before I put on my gloves. I should have done that each time I changed my gloves. I don't know what I was thinking when I put the pen into the bottle of normal saline. I couldn't get the layer off and I guess I just wasn't thinking. That would have contaminated the normal saline and I should have gotten a new bottle. I should not have put the bottle of normal saline in the trash bag and then used it. I should not have repositioned the dressing once I had [MEDICATION NAME] it down over the resident's rectum. It was contaminated. During an interview on 07/20/2020 at 3:45 PM, the ADON (Assistant Director of Nursing) stated, (Staff F's name) should not have used the normal saline or the foam dressing after she contaminated them. She should have washed her hands each time she changed her gloves. Review of the facility policy and procedures titled Dressing Change Policy # N-1310, last revision date: 12/06/2017 read, A clean dressing will be applied by a nurse to a wound as ordered to promote healing. Procedure: place supplies on prepped work surface, perform hand hygiene, apply gloves, remove and dispose of soiled dressing, remove gloves, perform hand hygiene, apply gloves, cleanse wound as ordered, remove gloves and perform hand hygiene, apply treatment as ordered and clean dressing, discard gloves and perform hand hygiene.