| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **105911** | A. BUILDING _____ B. WING _____ | **03/05/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **MANORCARE HEALTH SERVICES WEST PALM BEACH** | **2300 VILLAGE BLVD WEST PALM BEACH, FL 33409** |

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) |
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| F 0657<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and record review, the facility failed to follow the care plan for a resident complaining of pain for 1 of 1 sampled resident reviewed for pain (Resident #31). The findings included: Based on observation, interview, and record review, the facility failed to intervene and respond to a resident's complaint of pain for 1 of 1 resident reviewed for pain (Resident #31). The findings included: An interview was conducted with Resident #31 in bed on 03/02/20 at 12:00 PM. Resident #31 stated her heels were hurting and further stated they were putting some cream on them, but stopped a few days ago. Resident #31 stated they told her they would bring some more cream in, but they have not. Record review revealed Resident #31 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A Comprehensive assessment dated [DATE] documented Resident #31 was cognitively intact, and required extensive two-person assist with activities of daily living. A review of Resident #31's orders revealed an order dated 01/10/20 for skin prep to bilateral heels for skin prevention (prevention of pressure ulcers). The order was discontinued on 02/27/20. A review of Resident #31's care plan revealed a care plan for pain related to [MEDICAL CONDITION] and [MEDICAL CONDITION]. An intervention included to encourage/assist to reposition frequently to position for comfort. Resident #31 was care planned for at risk for alteration in skin integrity related to impaired mobility. An intervention was to observe skin condition with activities of daily living care daily and report abnormalities. An additional intervention included to provide preventative skin care routinely and as needed. Resident #31 was further care planned for Tinea Pedis (athlete's foot). An intervention included to use pillows and/or positioning devices as needed. An observation of Resident #31 was conducted on 03/04/20 at 10:30 AM in bed. Staff C, a Certified Nurse Assistant, was present in the resident's room. Staff C stated she was going to get the resident out of bed. Resident #31 complained of her heels hurting again. Staff C stated the resident has been complaining of feet/heel pain. An observation of Resident #31's heels was conducted with Staff C. Resident #31's heels were observed to be reddened and painful to touch. An interview was conducted with Staff D, a Licensed Practical Nurse, on 03/04/20 at 11:00 AM. Staff D stated Resident #31 had been complaining of pain in her feet. Staff D further stated the resident's heels were reddened and needed to be elevated while in bed. Staff D stated when the resident is up, she is fine. An interview was conducted with Resident #31 on 03/04/20 at 2:09 PM. The resident was observed sitting up in a wheelchair in the hallway. The resident stated her feet mostly hurt at night. The resident further stated her heels rub on the sheet. Surveyor asked the resident if her feet are elevated at night. Resident #31 stated they could not find a pillow to elevate her feet. An interview was conducted with the Unit Manager on 03/04/20 at 4:00 PM. The Unit Manger stated she did not know anything about Resident #31's complaint of heel pain. The Unit Manager stated she would have the Nurse Practitioner see the resident. An observation of Resident #31 was conducted on 03/05/20 at 11:02 AM. The resident was observed in bed, with heels elevated on pillows. The resident stated she did not have any pain last night since her heels were elevated. The resident's heels were observed pink and not painful to touch. |
| F 0689<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview and record review, the facility failed to adequately assess a resident post fall, and failed to investigate a fall for 1 of 4 sampled residents reviewed for falls (Resident #206). The findings included: Resident #206 was admitted to the facility for respite care on 08/19/19 with [DIAGNOSES REDACTED]. An admission/readmission screen dated 08/19/19 documented the resident as oriented to person and time, and able to communicate needs. A Discharge assessment dated [DATE] documented the resident as needed limited assistance for activities of daily living. A review of Resident #206's records revealed a progress note dated 08/24/2019 at 5:47 PM documented: Patient alert and oriented with some confusion,found sitting on the floor due to a fall without injury. Patient has swelling to the forehead,ice pack applied,monitoring vital signs MD (Medical Doctor) and family member made aware of that PM (night) care rendered, comfort and safety measure maintained, call light placed within reach. Further review of Resident #206's records lacked any evidence that a neurological examination was performed. Resident #206 was discharged home on[DATE] at 12:50 PM. The facility lacked an investigation of Resident #206's fall. A Review of the facility's policy Neurological Evaluation dated 01/19 documented, A neurological evaluation is done following an unwitnessed fall when a head injury may be suspected. An interview was conducted with the Director of Nursing (DON) on 03/05/20 at 2:12 PM. The DON stated a neurological examination should have been performed on Resident #206. The DON further stated an investigation should have been done on the resident's fall to assess the root cause of the fall. |
| F 0755<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, record review, policy review and interview, it was determined, the clinical staff failed to ensure controlled substances were accurately reconcile. This failure affected 1 of 3 sampled residents (Resident #57). The findings included: A Medication Administration Observation was conducted on 03/04/20 starting at 5:20 PM revealed Staff A, a Licensed Practical Nurse, preparing medications for Resident #57. The nurse removed a bottle of [MEDICATION NAME] HCL solution 5 milligrams/5 milliliter (ml), Controlled Substance, labeled as give 5 ml via [DEVICE] every six hours for pain. At the time, it was observed the bottle of [MEDICATION NAME] had approximately 160 milliliters left, which contradicts the controlled record, noting 145 milliliters were left in the bottle. Staff A continued the medication pass and removed a [MEDICATION NAME] syringe to remove the liquid medication. After preparing the medications, Staff A had an additional [MEDICATION NAME] HCL 5.5 milliliters left in the cup and subsequently wasted this amount of medication with another nurse. A Medication Storage Observation was conducted on 03/05/20 at 8:56 AM revealed Staff B, a Licensed Practical Nurse, attending the medication cart. Upon request, Staff B removed the bottle of [MEDICATION NAME] for Resident #57 and stated there are 150 ml left in the bottle. Observation confirmed there were 150 ml left in the bottle which contradicts the Controlled Substance Record documenting the 130 ml as of 03/05/20 at 5:34 AM. Review of the Medication Administration Records dated 02/2020 and 03/2020 indicates the nurses signed off the administration records attesting Resident #57 received the prescribed [MEDICATION NAME], every day. There are no noted omissions or refusals. Interview with the |

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 0755<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | (continued... from page 1)<br>Director of Nursing (DON) and Staff B conducted on 03/05/20 at 9:04 AM revealed Staff B explained the liquid [MEDICATION NAME], typically comes with a syringe, she does not use a [MEDICATION NAME] syringe, but acknowledged the [MEDICATION NAME] syringes are stored in the narcotic compartment of the medication cart. The staff stated two nurses reconciled the narcotics every shift and stated most nurses are okay with having more of the solution in the bottle than the amount stated on the controlled substance record. The DON observed the bottle and confirmed there is 150 ml of [MEDICATION NAME] left and questioned why the nurse used a [MEDICATION NAME] syringe instead of a measuring cup for a 5 ml dose and if raised the possibility the resident is not receiving the correct amount of the medication. The DON acknowledged the narcotic reconciliation is not accurate. Facility policy titled Inventory of Controlled Substances dated 08/2018 documents This section sets forth the procedures for inventory control of controlled substances. The nursing center should maintain separate individual controlled substances records in the pharmacy provided declining inventory form. if a controlled substance is provided by a third party pharmacy without a declining inventory record, Resident's Controlled substances Record may be used. The record includes drug name, strength, dosage form, dosage, and total quantity received by the nursing center, the date and time of administration and signature of the person administering the drug. The nursing center should ensure that the incoming and outgoing nurses count all controlled substances at the change of each shift and whenever there is an exchange of medication cart keys, and document on a narcotic and controlled substance shift to shift count sheet. The nursing center should reconcile the total number of controlled medications on hand, add newly received medications to the inventory and remove medications that are completed or discontinued from the inventory, pursuant to the master-controlled substance log. Reconcile the number of doses remaining in the package to the number of remaining doses recorded on the pharmacy provided declining inventory form, also known as proof of use form. Routinely reconcile the number of doses remaining in the package to the number of remaining doses recorded on the declining inventory form to the medication administration record. |
| F 0812<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | **Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.**<br><br>Based on observation and interview, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety. The findings included: On 03/02/20 at 9:00 AM, an initial tour in the main kitchen was conducted, accompanied by the Food Service Director, the following was observed: 1. An inspection of the walk in refrigerator revealed a tray of pureed desert that was not dated. 2. Two five pound containers of cottage cheese that was to be used by date 02/23/20, was also observed in the walk in refrigerator. 3. During the tour, a visit to the Dry storage room, a #5 can of stew tomato that was dented was found on the shelf. On 03/03/20 an during interview with the Consultant Dietitian and the Food service Director, the findings were reviewed, and confirmed. |
| F 0842<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview and record review, the facility failed to maintain a completed record for 1 of 1 sampled residents reviewed for Baker Act (Resident #206). The findings included: Resident #206 was readmitted to the facility for respite care on 10/08/19. An interview was conducted with the Nursing Home Administrator (NHA) on 03/05/20 at 2:00 PM. The NHA stated she could not find the closed records for Resident #206 admission date of [DATE], including the Admission Agreement between patient and center. The NHA was able to provide the Baker Act forms for Resident #206, which she acquired from the hospital. Resident #206 was Baker Acted on 10/10/19 and sent out to the hospital. |