STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967726	07/25/2018
NAME OF PROVIDER OR SUPPLIER RESIDENCES OF NICEVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 2300 NORTH PARTIN DRIVE NICEVILLE, FL 32578	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

An unannounced complaint survey for allegations contained within CCR#2018008929 was conducted at , Residences of Niceville, state license #11712, on & . Deficient practice was identified at the time of the survey.

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on interview and record review, the facility failed to honor a resident's right to live in a safe and decent environment free from neglect by failing to treat the resident's wounds. This failed practice led to and hospitalization for 1 of 4 residents sampled (#4).

Findings include:

Resident #4's medical record, including Hospice visit notes, was reviewed and revealed multiple skin concerns.

The resident had a left calf , originally observed as a " ." Facility notes revealed the was found to be warm to the touch with . The Hospice nurse was notified, and obtained an order for an oral to treat the . Further, facility staff contacted Hospice multiple times and obtained treatment orders, which were followed. The further progressed and was noted by the Hospice licensed practical nurse (LPN) to be a pressure injury on . When the Hospice registered nurse (RN) visited on , the was found to be scabbed over with no redness or , however; during this visit a right thigh scabbed area was noted. The physician was notified of the but did not provide any treatment orders. Facility staff found an open area to the resident's left lower leg on and noted a bandage was applied. Hospice was notified via facsimile on but no orders were ever given for treatment to the area. Facility staff further failed to document any care or further contact with Hospice regarding the left leg . The resident was also noted as having a right thigh , originally identified by facility staff , and a bandage was applied. The facility further notified Hospice and the physician regarding the . Per nurse notes, the bandage to the right upper thigh was changed on . The Hospice RN observed the on , but no orders were provided regarding treatment. Facility nursing notes revealed the bandage to the was replaced on due to a moderate amount of drainage. No documentation revealed Hospice nor the physician were notified of the change in the .

Nursing notes on at 10:30 PM revealed the resident #4 with a temperature of 101.6 degrees.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967726	07/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESIDENCES OF NICEVILLE	2300 NORTH PARTIN DRIVE NICEVILLE, FL 32578

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

Hospice was notified and was provided. The Hospice nurse arrived the facility on at 11:42 PM and found the resident to have an axillary temperature of 104.4 degrees. During assessment of resident #4, the Hospice RN found the right thigh to be covered with a bandage dated . Once the bandage was removed, it was noted to be saturated with (containing pus) drainage. The was assessed to be 4.5 centimeters (cm) by 6.5 cm. The bed was deep red with areas of yellow . A moderate amount of gray drainage was present with a foul odor. The left lower leg was assessed and also was found to have , foul smelling drainage. The was approximately 2 cm in diameter but had an area of approximately 6 cm of redness, , and heat surrounding the . Based on resident condition, the resident was emergently transferred to a local emergency treatment.

The Hospice RN followed the resident to the local emergency . Upon arrival, emergency changed the resident into a hospital gown. While changing the resident's clothing, the Hospice RN observed a large hematoma on the resident's right upper arm. The area was observed to be bright red, heated, and . No facility records were found to note the hematoma.

The hospital records were reviewed and revealed concerns for , and . Physician assessment revealed skin concerns of a 2 cm circular open to the left lateral , a 1 cm circular to the right lateral , and a right upper arm with (redness), hot and hard. Multiple were also noted.

Resident #4 subsequently expired on . The certificate was reviewed and revealed causes of as acute , failure, acute , , and .

Class II

0031 - Resident Care - Third Party Services - 58A-5.0182(7) FAC

Based on staff interview and record review, the facility failed to ensure collaboration and coordination with third party services, specifically Hospice, to ensure care was provided to 3 of 4 residents sampled (residents #2, #3, and #4).

Findings include:

Resident #2
Resident #2's medical record was reviewed on and revealed two unstageable pressure injuries to his . The last Hospice note in the resident's medical record was dated and

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967726	07/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESIDENCES OF NICEVILLE	2300 NORTH PARTIN DRIVE NICEVILLE, FL 32578

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

revealed #1 to be 1.5 centimeters (cm) x 1 cm x 0.5 cm with a black, bed with no odor. #2 was described to be 2 cm x 1.5 cm x 0.5 cm, also with no odor. The clinical notes revealed the Hospice nurse collaborated with the Hospice physician for new orders, and further revealed, " care provided as per new order." No physician order existed within the record.

The Executive Director was interviewed at 12:45 PM. She reviewed resident #2's medical record and confirmed no Hospice visit notes after were present, nor any physician orders for care on or after were in the record. The last physician order within resident #2's record was dated .

Resident #2's medical record was reviewed on and revealed a Hospice nurse visit dated . The note revealed only one , a pressure injury to the . The size of the was noted to be increased to 3 cm x 2.5 cm. A physician's order dated was also found. Orders were to cleanse the resident's with cleanser, , dry, and apply to wounds and peri area every shift and as needed for incontinence. Resident #2's medication observation record (MOR) was reviewed for , and did not reveal an order for care. The nurse notes for the resident were reviewed and revealed no documented care performed on , , and .

Resident #3
Resident #3's medical record was reviewed and revealed two pressure injuries to the resident's . The last Hospice nursing note within the resident's medical record was dated and revealed no open areas to the resident's . A physician's order dated revealed only one pressure injury to . The order indicated the area should be cleaned with normal and cleanser, Emu aid and a dry dressing to be applied three times a week by the Hospice nurse. The facility nurse was only to do the dressing changed if the dressing became soiled or dislodged.

The Executive Director reviewed the chart on at 12:45 PM and confirmed the absence of physician orders after and nurse notes after .

Resident #3's medical record was reviewed on and revealed a Hospice nurse visit dated . #1 pressure injury was found to be 0.5 cm x 0.5 cm. #2 pressure injury was found to be 0.3 cm x 0.3 cm. A physician's order, dated , was then found to order care performed by Hospice nurses twice weekly and facility nurses to perform care five times weekly. Orders were to cleanse to right and with cleanser, apply emu aid and cover with foam bordered dressing daily. The MOR for resident #3

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967726	07/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESIDENCES OF NICEVILLE	2300 NORTH PARTIN DRIVE NICEVILLE, FL 32578

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

for , was reviewed but did not reveal an order for care. The nurse notes for resident #3 were reviewed and revealed no documented care performed by either Hospice nor the facility on and .

Resident #4
Resident #4's medical record was reviewed and identified multiple wounds. On , a left lower leg would was found by Hospice to be scabbed over with no redness or . Facility staff found an open area to the left lower leg on and noted a bandage was applied. Hospice was notified via facsimile on but no orders were ever given for treatment to the area. Facility staff failed to document any care or further contact with Hospice regarding the left leg .
A right thigh was originally identified by facility staff on and a bandage was applied. The facility further notified Hospice and the physician regarding the . Per nurse notes, the bandage to the right upper thigh was changed on . The Hospice nurse observed the on , but no orders were provided regarding treatment. Facility nursing notes reveal the bandage to the was replaced on due to a moderate amount of drainage. No documentation revealed Hospice nor the physician were notified of the change in the .
Nursing notes on at 10:30 PM revealed a temperature of 101.6 degrees for resident #4. Hospice was notified and was provided. The Hospice nurse arrived the facility on at 11:42 PM and found the resident to have an axillary temperature of 104.4 degrees. During assessment of resident #4, the Hospice nurse found the right thigh to be covered with a bandage dated . Once the bandage was removed, it was noted to be saturated with , (containing pus) drainage. The was assessed to be 4.5 cm x 6.5 cm. The bed was deep red with areas of yellow . A moderate amount of gray drainage was present with a foul odor. The left lower leg was assessed and also was found to have , , foul smelling drainage. The was approximately 2 cm in diameter but had an area of approximately 6 cm of redness, , and heat surrounding the . Based on resident condition, the resident was emergently transferred to a local emergency treatment. The Hospice nurse followed the resident to the local emergency .
Upon arrival, emergency changed the resident into a hospital gown. While changing the resident's clothing, the Hospice nurse observed a large hematoma on the resident's right upper arm. The area was observed to be bright red, heated, and . No facility records were found to note the hematoma. Hospital records were reviewed and revealed concerns for , and .
Resident #4 subsequently expired on . The certificate was reviewed and revealed causes of as acute , , failure, acute , , and , .

An interview with the Executive Director on at 10:00 AM revealed care was performed by both Hospice and the facility. She stated Hospice was responsible for writing the orders. If the treatments were only once or twice a week, Hospice would perform the care. If the order was

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967726	07/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESIDENCES OF NICEVILLE	2300 NORTH PARTIN DRIVE NICEVILLE, FL 32578

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

for daily dressing changes, Hospice would perform the care twice a week and the facility would perform care on days Hospice did not.

An interview was conducted with nurse B on at 11:00 AM. She stated the process for care recently changed. She revealed Hospice previously performed all the care in the building and facility nurses did no dressing changes. She revealed the process previously was to chart the resident had a and then notify Hospice of its presence but she would do no treatment for the . She stated in the past month or two, the process changed and now responsibilities for care was shared between the facility nurses and hospice nurses. She revealed she was unsure if there was a policy regarding who was responsible for dressing changes and further denied knowing how to access the policies and procedures of the facility. She further denied any education regarding treatments and revealed she only documented if she did the treatment on a nurse note.

An interview with Hospice nurse C was conducted on at 11:16 AM. She revealed care was done by the facility nurse. She revealed once a was found, the nurse should call the physician and obtain an order. If treatments were ordered twice weekly, the hospice nurse would perform the treatment but if it was ordered daily, both Hospice and the facility shared the responsibility for completing treatments. She further stated care was documented in her clinical notes and revealed they were delivered to the facility either weekly or twice a week. Upon delivery, the notes would be placed in the respective residents' charts.

An interview was conducted with the Director of Resident Services (DORS) on at 2:40 PM. She revealed Hospice was previously providing all care, but now facility nurses were responsible for the treatments. She stated the Hospice nurse told them the facility was responsible for contacting the resident's physician and obtaining orders for care. She stated, "We are all very by this because they are supposed to be caring for the whole resident, not just the parts they want to." A second interview with the DORS on at 8:30 AM revealed Hospice regularly would bring in orders for the physician to sign and leave them in the physician's box. She revealed some orders that were left for the physician to sign were never relayed to the facility to start performing.

The Executive Director revealed on at 9:30 AM that she had contacted Hospice and requested they bring in all documentation on the residents they were seeing. She stated Hospice told her they were supposed to bring in documentation every two weeks but would start doing it weekly in the future.

An interview was conducted with the DORS on at 11:15 AM. She revealed the facility process was not to put the order for care on the MOR. She stated staff were just supposed to write a

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967726	07/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESIDENCES OF NICEVILLE	2300 NORTH PARTIN DRIVE NICEVILLE, FL 32578

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

nurse note when they performed care. She revealed she was the nurse taking care of resident #3 on and revealed she forgot to change the resident's dressing. She stated she might not have forgotten if it had been on the MOR.

An interview with the DORS was conducted on at 11:24 AM. She revealed that despite being aware the failure to perform care for resident #4 resulted in hospitalization in , the facility failed to take any action to ensure both the facility and Hospice collaborated to ensure care would be performed for all residents per physician orders. This failed practice was evidenced by care failing to be provided to two additional residents, #2 and 3, in .

Class II

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on staff interview and record review, the facility failed to ensure licensed staff performed care for 3 of 4 residents sampled, which led to the hospitalization of resident #4 and an increase in sizes for residents #2 and #4.

Findings include:

Resident #2
Resident #2's medical record was reviewed on and revealed two unstageable pressure injuries to his . The last Hospice note in the resident's medical record was dated and revealed #1 to be 1.5 centimeters (cm) x 1 cm x 0.5 cm with a black, bed with no odor. #2 was described to be 2 cm x 1.5 cm x 0.5 cm, also with no odor. The clinical notes revealed the Hospice nurse collaborated with the Hospice physician for new orders, and further revealed, " care provided as per new order." No physician order existed within the record.

The Executive Director was interviewed at 12:45 PM. She reviewed resident #2's medical record and confirmed no Hospice visit notes after were present, nor any physician orders for care on or after were in the record. The last physician order within resident #2's record was dated .

Resident #2's medical record was reviewed on and revealed a Hospice nurse visit dated . The note revealed only one , a pressure injury to the . The size of the was noted to be increased to 3 cm x 2.5 cm. A physician's order dated was also found. Orders were to cleanse the resident's with cleanser, dry, and apply , to

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967726	07/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESIDENCES OF NICEVILLE	2300 NORTH PARTIN DRIVE NICEVILLE, FL 32578

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

wounds and peri area every shift and as needed for incontinence. Resident #2's medication observation record (MOR) was reviewed for and did not reveal an order for care. The nurse notes for the resident were reviewed and revealed no documented care performed on , , and .

Resident #3
Resident #3's medical record was reviewed and revealed two pressure injuries to the resident's . The last Hospice nursing note within the resident's medical record was dated and revealed no open areas to the resident's . A physician's order dated revealed only one pressure injury to . The order indicated the area should be cleaned with normal and cleanser, Emu aid and a dry dressing to be applied three times a week by the Hospice nurse. The facility nurse was only to do the dressing changed if the dressing became soiled or dislodged.

The Executive Director reviewed the chart on at 12:45 PM and confirmed the absence of physician orders after and nurse notes after .

Resident #3's medical record was reviewed on and revealed a Hospice nurse visit dated . #1 pressure injury was found to be 0.5 cm x 0.5 cm. #2 pressure injury was found to be 0.3 cm x 0.3 cm. A physician's order, dated , was then found to order care performed by Hospice nurses twice weekly and facility nurses to perform care five times weekly. Orders were to cleanse to right and with cleanser, apply emu aid and cover with foam bordered dressing daily. The MOR for resident #3 for was reviewed but did not reveal an order for care. The nurse notes for resident #3 were reviewed and revealed no documented care performed by either Hospice nor the facility on and .

Resident #4
Resident #4's medical record was reviewed and identified multiple wounds. On , a left lower leg would was found by Hospice to be scabbed over with no redness or . Facility staff found an open area to the left lower leg on and noted a bandage was applied. Hospice was notified via facsimile on but no orders were ever given for treatment to the area. Facility staff failed to document any care or further contact with Hospice regarding the left leg .
A right thigh was originally identified by facility staff on and a bandage was applied. The facility further notified Hospice and the physician regarding the . Per nurse notes, the bandage to the right upper thigh was changed on . The Hospice nurse observed the on , but no orders were provided regarding treatment. Facility nursing notes reveal the

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967726	07/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESIDENCES OF NICEVILLE	**2300 NORTH PARTIN DRIVE NICEVILLE, FL 32578**

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

bandage to the was replaced on due to a moderate amount of drainage. No documentation revealed Hospice nor the physician were notified of the change in the Nursing notes on at 10:30 PM revealed a temperature of 101.6 degrees for resident #4. Hospice was notified and was provided. The Hospice nurse arrived the facility on at 11:42 PM and found the resident to have an axillary temperature of 104.4 degrees. During assessment of resident #4, the Hospice nurse found the right thigh to be covered with a bandage dated . Once the bandage was removed, it was noted to be saturated with (containing pus) drainage. The was assessed to be 4.5 cm x 6.5 cm. The bed was deep red with areas of yellow . A moderate amount of gray drainage was present with a foul odor. The left lower leg was assessed and also was found to have , foul smelling drainage. The was approximately 2 cm in diameter but had an area of approximately 6 cm of redness, , and heat surrounding the . Based on resident condition, the resident was emergently transferred to a local emergency treatment.
Hospital records were reviewed and revealed concerns for , and . Resident #4 subsequently expired on . The certificate was reviewed and revealed causes of as acute , , failure, acute , , and .

An interview with the DORS was conducted on at 11:24 AM. She revealed that despite being aware the failure to perform care for resident #4 resulted in hospitalization in , the facility failed to take any action to ensure both the facility and Hospice collaborated to ensure care would be performed for all residents per physician orders. This failed practice was evidenced by care failing to be provided to two additional residents, #2 and 3, in .

Class II

0160 - Records - Facility - 58A-5.024(1) FAC

Based on staff interview and record review, the facility failed to maintain Hospice records, including visit notes and physician orders, for 4 of 4 Hospice residents reviewed (#1, #2, #3, and #4).

Findings include:

Resident #1's medical record was reviewed on and revealed a to the resident's left hand. No Hospice nursing notes were observed in the medical record since . Additionally, no Hospice aide notes existed after . The last physician order was dated . No physician orders existed for the treatment of the .
An interview was conducted with the Executive Director on at 12:45 PM. She reviewed the

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967726	**07/25/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESIDENCES OF NICEVILLE	**2300 NORTH PARTIN DRIVE NICEVILLE, FL 32578**

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

record and confirmed no documentation existed after those dates.

Resident #2's medical record was reviewed on and revealed two unstageable pressure injuries to his . The last Hospice note within the resident's medical record was dated . No Hospice aide notes existed after . The last physician order written for the resident was dated .
The Executive Director was interviewed on at 12:45 PM. She reviewed resident #2's medical record and confirmed no Hospice visit notes after and no physician orders for care on or after .

Resident #3's medical record was reviewed and revealed two pressure injuries to the resident's . The last Hospice nurse note within the resident's medical record was dated and revealed no open areas to the resident's . A physician's order dated revealed only one pressure injury to . The order indicated the area should be cleaned with normal and cleanser, Emu aid and a dry dressing to be applied three times a week by the Hospice nurse. The facility nurse was to only do the dressing change if soiled or dislodged.
The Executive Director reviewed the chart on at 12:45 PM and confirmed the absence of physician orders after and nurse notes after .

Resident #4 ' s medical record was reviewed. The resident was discharged from the facility .
While the facility maintained the facility records, no Hospice records could be located.

The Executive Director revealed on at 9:30 AM that she had contacted Hospice and requested they bring in all documentation on the residents they were seeing. She stated Hospice told her they were supposed to bring in documentation every two weeks but would start doing it weekly in the future.

Class III