STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105072	A. Building B. Wing	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lexington Healthcare and Rehabilitation Center	6300 46th Ave N Saint Petersburg, FL 33709

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37999 Based on observations, record reviews, and interviews the facility failed to update the pressure ulcer treatment orders of one resident (#6) out of three residents sampled for obtaining and the implementation of wound care orders in a timely manner. Findings included: Review of the Admission Record revealed Resident #6 was admitted on [DATE]. Resident #6 had diagnoses not limited to unspecified stage pressure ulcer of sacral region and unspecified protein-calorie malnutrition. A review of Resident #6's Order Summary Report, active as of 11/21/22, identified a physician order, dated 10/27/22, that instructed staff to Clean sacrum with normal saline (NS) and pat dry. Pack sacrum wound with Silver Alginate (AG) and cover with a foam gauze, daily and as needed (prn) for incontinence, every shift for wound care. A review of Resident #6's November 2022 Treatment Administration Record (TAR) indicated the above physician order for packing the resident's wound with Silver Alginate had been completed fifty-five times out of sixty opportunities, from November 1, 2022 through the night shift on November 20, 2022. Additional review of the November TAR, showed of the total of fifty-five times the wound was treated, Resident #6's wound was packed with Silver Alginate 15 times following the above physician's order from 11/16/22 to 11/20/22. The care plan, initiated on 10/7/22 and revised on 10/10/22, for Resident #6 identified the resident was noted to have a sacrum pressure ulcer with corresponding interventions that included: Perform wound treatments as ordered, and Wound care physician services to follow. Resident #6's clinical record included an Advanced Registered Nurse Practitioner (ARNP) progress note, dated 11/16/22, that identified the chief complaint was a Comprehensive skin and wound evaluation for Sacrum stage 4 pressure injury. The plan of care indicated the wound rounds were completed and reconciled with (the) wound nurse and that staff were made aware that wound rounds were completed and of any changes in treatment plan. The note indicated the ARNP recommended changing treatment to collagen matrix dressing with silver (and) cover with border foam dressing. (continued on next page)

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/21/22 at 2:45 p.m., an interview was conducted with Staff A, Licensed Practical Nurse/Unit Manager (LPN/UM)) and Staff B, Wound Care Nurse (WCN). Staff A stated residents' wound care orders may come from the hospital or if not, a wound care provider comes to the facility twice a week and assesses new admissions. The UM confirmed the facility does follow the orders provided by the wound care vendor. Staff B reported following up on recommendations and putting orders into the electronic record. Staff A and Staff B reviewed the Wound Care provider's note, dated 11/16/22, and reported they were unaware of the ARNP's recommendation to change the wound care order for Resident #6 to a collagen matrix with silver. Staff B, WCN stated she had rounded with the practitioner (ARNP), was unaware of the change but would check her notes. Staff B left the interview. Staff A, LPN/UM stated the ARNP had access to the residents' clinical record and was capable of putting orders into the computer, that staff rounded with the ARNP and a laptop, and if an order was changed; it would be input at that time. Staff A reported the ARNP, who had rounded on 11/15/22 (day before the note was written), was not the normal provider and the ARNP was not able to give orders just recommendations, as they had recently been on orientation, and recommendations would have to be clarified with the normal provider. Staff B, WCN returned to the interview with notes taken on 11/15/22. She confirmed the order should have been changed to Collagen Silver. Staff B confirmed the ARNP could give orders then rescinded and stated she could give recommendations. Review of the medical record revealed it was silent of documentation as to why the treatment was not changed based on the ARNP's recommendation. The Director of Nursing stated, at 3:18 p.m. on 11/21/22, that her expectation was the recommendation would have been followed up on and staff would have documented the reason for keeping the order as it was previously. She stated the WCN had been speaking with the normal Wound Care provider to keep the treatment as it was because the wound was getting better and the resident kept pulling the urinary catheter out. The facility did not provide the policy for obtaining wound care orders.