STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105641	A. BUILDING _____ B. WING _____	**08/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NSPIRE HEALTHCARE KENDALL	**9400 SW 137TH AVENUE KENDALL, FL 33186**

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 0558 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to meet resident care needs and preferences. This was evidenced by the failure to assist the resident (Resident #3) in maintaining a dignified wellbeing in achieving functioning independents for 1 out of 3 sampled residents. The facility failed to ensure call light was within reach for Resident #3 who is bedbound and requires use of the call bell to request staff assistance for personal care. The findings include: Review of Resident #3's medical record indicated that the resident was readmitted to the facility on [DATE] after a hospitalization . The resident has medical diagnosis' including [MEDICAL CONDITION] of the lower extremities, obesity, oxygen (O2) dependence and generalized weakness. In an observation and interview with Resident #3 on 8/6/2020 at 9:00 AM, the resident was observed in bed with the head of the bed elevated and was observed to be utilizing oxygen via a nasal cannula. The resident's call bell was tied in a knot on the side rail behind the resident, preventing the resident from reaching it. Resident #3 who is alert and oriented stated that she is unable to ambulate due to [MEDICAL CONDITION] and lower body weakness and unable to get out of bed to use the toilet, so she wears an incontinence brief. Resident #3 stated that she is aware when she is soiled with urine/feces and relies on the facility staff to change her. Resident #3 stated she is able to re-position herself in the bed but she is only able to perform upper body self-care. She stated that she prefers to use soap and water to be cleansed, but staff insist on using disposable wipes which cause irritation to her skin. Resident #3 stated that due to the pandemic, staffing has been stretched very thin. She stated that at times she believes there is not enough staff available when she calls for assistance with her care. She stated that recently, (she was unable to recall the exact date) she had been changed by an aide around 1:00 PM and at 6:30 PM she used her call bell to alert staff she needed to be changed. She stated that an aide did not respond until 11:00 PM and then the aide apologized that there was not enough staff. Resident #3 stated that she knows the staff are exhausted and she understands the situation, but she is unable to clean herself. Resident #3 stated that she prefers to be clean and fresh smelling, not soiled since this is upsetting to her. The resident stated that she has developed a rash between her buttock cheeks which is being treated with cream. In an additional observation of Resident #3 at 9:53 AM, the call bell remained tied to the back of side rail, out of the resident's reach. In an additional observation of Resident #3 at 10:00 AM, the resident was observed performing upper body care with a water basin and soap that was placed on the over bed table. The call bell was positioned next to the resident's side. Review of Resident #3's care plans indicated a care plan dated 8/5/2020 , rash to bilateral gluteal folds. Interventions included to avoid scratching and keep hands and body parts from excessive moisture and do not use harsh detergent soaps and fragrances. Further review of the resident's care plans indicated a care plan dated 1/14/2019 for Activities of Daily Living (ADL) care due to limited mobility and limited range of motion (ROM), the interventions included encourage the resident to use call bell to call for assistance. In an interview on 8/6/2020 at 9:30 AM with an aide who was caring for Resident #3, she stated that Resident #3 is alert and oriented and can make her wishes and preferences known. The aide stated that Resident #3 is unable to get out of bed for toileting and required staff assistance to clean and change the resident's brief. Review of Resident #3's Medication Administration Record [REDACTED]
F 0641 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews the facility failed to accurately code the Minimum Data Set (MDS) for one (Resident #1) out of six residents sampled for falls. As evidenced by: Resident #1 who had a history of [REDACTED]. There were 81 residents residing in the facility at the time of this survey. The findings included: Review of the demographics face sheet revealed, resident #1 was admitted on [DATE] with clinical [DIAGNOSES REDACTED]. Review of progress notes dated 05/23/2020 time stamped 5:14 AM revealed, resident #1 had a fall at around 2:45 AM and was found lying on the floor on his back in front of his bed by Certified Nursing Assistant (CNA). An assessment was conducted Resident. Resident #1 sustained a skin abrasion to the left elbow area. Progress notes dated 05/24/2020 time stamped at 8:53 AM revealed, resident #1 was found sitting on the floor of the 2300 hallway leaning back with hand extended for assistance. There was no complaint of pain and a small skin tear was noted to the right elbow and knee. Progress notes dated 05/30/2020 time stamped 14:41 revealed resident # 1 sustained a right knee skin tear after fall. Progress notes dated 06/09/2020 time stamped 21:37 revealed, resident #1 was noted kneeling on the floor in the 2300 hall with wheelchair overturned next to him, partially pinning him to the floor. Small abrasion to the left knee. Progress notes dated 06/09/2020 times tamped at 04:09 revealed, resident #1 was found at 10:00 pm sitting on the floor on the floor near the bed. Progress notes dated 06/19/2020 time stamped at 01:13 revealed, resident #1 was continuously attempting to get out of chair, while redirecting patient to sit down he became aggressive, hitting, and punching causing him to lose balance and fall. The resident was assisted back to his chair and assessed, and a small abrasion was noted to knee, no other injuries noted. Review of MDS Section J dated 07/27/2020 revealed resident #1 was not coded for falls, despite resident #1's history of multiple falls between the dates of May 23,2020 and June 19,2020. On 08/06/2020 at 3:59 PM during an interview with Staff G Registered Nurse MDS Coordinator. The concerns related to resident #1's MDS not being coded for falls was discussed. During the interview the Staff G called another MDS coordinator who stated, whoever completed the assessment for resident #1 did not document the falls. She stated another MDS coordinator had completed the assessment.
F 0755 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the availability and provision of routine and emergency medications to meet the needs of each resident. This was evidenced by, the failure to implement procedures for acquiring, receiving and administering of drugs in a timely manner for 1 of 3 sampled resident (Resident #2) who was prescribed antibiotic therapy for a systemic infection. The findings include: Review of Resident #2's medical record indicated the resident was admitted to the facility's 2nd floor North wing on 7/6/2020 for treatment of [REDACTED]. The resident was prescribed daily intravenous antibiotic therapy via a peripherally inserted central catheter (PICC). A PICC line is used to deliver medications, e.g. antibiotics directly to the large central veins near the heart and therefore eliminated frequent needle sticks for medication that is expected to last up to several weeks. Review of Resident #2's Medication Administration Record (MAR) for July 2020 indicated, physician orders [REDACTED]. Additionally, the resident was ordered pain medication for back pain, including [MEDICATION NAME], and [MEDICATION NAME]. Further review of the July 2020 MAR indicated that Resident #2 received [MEDICATION NAME] / [MEDICATION NAME] 2000 mg IV every 12 hours starting on 7/9/2020 at 9:00 PM thru 7/12/2020 at 9:00 PM. Review of the July 2020 MAR indicated Resident #2 did not receive the prescribed antibiotic medication dose starting on 7/13/ 2020 at 9:00 AM and 9:00 PM and on 7/14/2020 at 9:00 AM and 9:00

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 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) PM. The medication was resumed on 7/15/2020 at 9:00 AM as documented on the MAR. Review of the electronic nursing progress note, Nurse#H dated on 7/13/2020 at 12:08 PM indicated that the prescription for [MEDICATION NAME] / [MEDICATION NAME] 2 Gram (Gm) was not administered. The note indicated that the facility was Awaiting delivery from pharmacy. Review of electronic nursing progress note, Nurse #I dated on 7/13/2020 at 22:22 indicated medication [MEDICATION NAME] / [MEDICATION NAME] 2 Gm was pending pharmacy. Review of electronic nursing progress note, Nurse #I dated on 7/13/202 at 22:37 indicated the pharmacy was contacted. Office said patient has to be admitted into pharmacy system by the pharmacy admission department prior to sending medication. Will follow up in AM with morning nurse. Review of electronic nursing progress note, Nurse #B dated on 7/14/2020 at 10:31 AM indicated [MEDICATION NAME] / [MEDICATION NAME] 2 Gm was not administered. In an interview with Nurse #B on 8/6/2020 at 11:45 AM, she stated that she had received report from the night nurse on 7/14/2020 at 7:00 AM and was informed that Resident #2's antibiotic [MEDICATION NAME] / [MEDICATION NAME] 2 Gm had not arrived from the pharmacy. Nurse #B stated that she recalled that she had checked the emergency medication kit (E-Kit) for the medication and found no backup medication in the kit. She stated that she could not recall if she had called the pharmacy for an updated status on the antibiotic replacement. She stated that she did not contact Resident#2's physician or the Director of Nursing (DON) to inform them that the medication had not been administered on 7/13/2020 and the antibiotic medication remained unavailable on 7/14/2020. Nurse #B stated that she did not contacted the family about the delay with the prescribed medication treatment. The nurse reviewed her electronic progress note dated on 7/14/2020 at 10:31 AM and she was unable to recall any actions taken regarding obtaining the medication and confirmed that she had not documented any actions taken. On 8/6/2020 at 12:00 PM a request was made to the DON and North Unit nurse manager to provide any additional documentation that indicated the actions taken by facility nursing staff in obtaining the prescribed medication. During an interview conducted at that time, the DON stated that the nursing staff should contact the physician/ health care provider and the family/ representative when prescribed medications/ treatments are delayed or missed. She stated that she had not been notified of any medication issues with Resident #2. On 8/6/2020 at 4:00 PM the DON provided a copy of the facility internal 24 hour report/ change in condition report form dated on 7/14/2020- 2 North/ Shift 7 AM -7 PM. Review of the form revealed one notation for Resident #2 which stated [MEDICATION NAME] 2 GM not available. United Pharmacy was called for follow-up. Medication will be delivered STAT. Report given to upcoming nurse. The report was signed by Nurse #B. No additional documentation was noted on the form. In an interview with Resident #2's case manager on 8/6/2020 at 1:56 PM she stated that the resident's insurance would cover the prescribed antibiotic medication from the facility contracted pharmacy. She stated that she had not received any calls from either the facility or pharmacy regarding any issues or a request for needed authorization in obtaining medication for Resident #2. An observation was made on 8/6/2020 at 11:00 AM of the 2nd floor south wing medication storage room. The observation was conducted with the DON, unit nurse #F and unit nurse #G. There were three E-kits labeled: Intravenous (IV)solutions; IV antibiotics; and Other medications) observed on top of the counter, each of the kits had no seal attached. Nurse #F stated that when the kits are complete from pharmacy there is a green seal attached to each kit. She stated when the nurse opens the e-kit for a medication, the nurse should then fill out a emergency drug kit slip, a double copy form(white/ yellow) located in the drawer below the kits. Nurse #F stated that the slip should be completed entirely, to include medication name, dose removed, quantity along with the number from the broken green seal. The nurse stated that a red seal should be placed on the kit indicating that a medication had been removed. Nurse #F stated that the nurse should fax the pharmacy a copy of the completed slip and then place the white slip portion inside the kit, and seal it with a red seal. Nurse #F stated that the yellow copy should remain in the logbook for reference. Both nurse #F and nurse #G stated that the pharmacy does not send a confirmation of the replacement order. The DON stated that if a backorder situation occurred with medication supplies, she would receive an email alert from the pharmacy, but the facility does not routinely receive any acknowledgement or estimated time for medication replacement. The DON stated that due to the pandemic, the pharmacy will bring ordered medications every Thursday, but emergency delivery is available when necessary. The DON stated that she expects a staff nurse to follow the facility pharmacy policy when opening and removing medications from the E-kits. She stated that possibly a new nurse may have opened the kits and was unfamiliar with the facility policy. Observation of the E-kit #1 showed a white slip located inside the kit which showed [MEDICATION NAME] 250 mg x 2 was removed on 7/31/2020. E-Kits #2 and #3 where open and no white slips were observed inside the kits. Review of the Emergency Drug Kit Slip logbook indicated the last documented slip, dated on 7/31/202 5:30 PM, showing [MEDICATION NAME] 250 mg x 2 was removed. The DON stated that there was no way to know when or if the pharmacy had been notified of the medication use/ removal or when the medication replacement was expected. An observation was made on 8/6/2020 at 11:30 AM of the 2nd floor north wing medication storage room with the DON and North Wing Unit Nurse Manager, three E-kits were observed with red tabs attached. The Unit Manager stated that there was no emergency drug kit slip logbook available at that time for review and a replacement book had been ordered. In an interview with the facility Consulting Pharmacist on 8/6/2020 at 4:15 PM, he was informed of the surveyor's medication observations and investigation results. He confirmed that the facility has a contract with an outside pharmacy and that the pharmacy provides resident medications, along with emergency medications/ e-kits for the facility. He stated that the antibiotic, [MEDICATION NAME] / [MEDICATION NAME] was a common antibiotic treatment for [REDACTED]. The Pharmacist stated that he was unaware of any backorder situation with that medication and he expressed that the pharmacy should be able to fulfill any order requested in a timely manner. The pharmacist was asked about the facility's failure to provide prescribed antibiotic medication to Resident #2, and he stated that one missed dose can sometimes occur, but he would expect the facility nursing staff to contact/ follow-up with the pharmacy and also contact the physician/health care provider for any orders to address any missed medication doses. He was informed about the E-kits observations on both the north and south wings, and he stated that he would be reviewing the ordering policy /procedures and make suggestions to provide accountability when medications are used from the e- kits. He stated that based on the information provided he agreed that there were multiple opportunities for improvement and he would be evaluating the facility policies on his next visit to the facility.
F 0804 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.** Based on observations, interviews, and record reviews, the facility failed to maintain the required food temperature during mealtime food delivery. As evidenced by the test tray and food delivered to one resident (resident #3) out of one sampled resident during meal time was below the appropriate food temperature. This facility's deficient practice has the potential to affect 81 residents eating by mouth residing in the facility at the time of the survey. The findings included: On 08/06/2020 at 12:57 PM resident #3, stated revealed the meals (especially breakfast) are usually cold when received. On 08/06/220 at 3:50 PM Staff J, Dietitian and Food Service Manager revealed that the food service had no issues or complaints for a while about the food temperatures. They had this issue 6 months ago and were monitoring the food temperatures of the food trays. Staff J explained that a test tray is done monthly to check the temperatures of the food when it reaches the floor. Staff J stated that the food temperature should be at least 135 degrees Fahrenheit (F) when the food cart arrive to the floor. Observation of the tray line food temperature on 08/06/2020 at 4:38 PM accompanied by Staff J, Dietitian and Food manager revealed, the temperature of the breaded chicken was 140 F and broccoli was 130 F. The Dietitian stated that the minimum food temperature in the tray line should be 140 F. The broccoli was reheated until reach 135 F. Observation meal delivery and test tray on 08/07/2020 at 5:04 PM on the South Unit revealed that as soon the Certified Nursing Assistant (CNA) delivered the food tray to resident #3. Staff J picked the test food tray from the food cart to check the food temperatures. The food temperatures on the food test tray revealed, the breaded chicken was 110 F, Yellow rice 120 F, Broccoli 110 F and the soup 115 F. Staff J at this time stated that the food temperature should be at least 135 F. Record review of the Policy and Procedures for Food Temperatures, last revision date 07/30/2018 revealed that The food temperatures are monitored at all critical points to ensure safety and acceptability. It further showed that the hot food items must be 135 degrees Fahrenheit or above when leaving the food area and the temperatures on the serving line would be taken by the cook approximately at 10 minutes before the start of tray service. If an item is not at least 150 degrees F, it will be removed from the line, reheated to a minimum of 155 and returned to the steam table.
F 0921 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** Based on observations, interviews, and record reviews, the facility failed to maintain a clean and sanitary environment in

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F 0921 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) one (North wing central shower/bath) out of two central shower/bathrooms in the facility, as evidenced by visibly soiled shower room floors with brown matter. This facility's deficient practice has the potential to affect all residents in the facility that use the common showers. There were 91 residents residing in the facility at the time of the survey. The findings included: Observation on 08/06/2020 at 10:06 AM of the central bath on the north wing of the facility, revealed visibly brown like colored stains on the floor in the wet shower area. (photographic evidence) On 08/06/2020 at 10:24 AM Staff A, Certified Nursing Assistant (CNA) revealed her responsibilities while making rounds included making sure the central bath is cleaned and disinfected between residents. Staff A stated that shower chairs and everything that the patients touched had to be cleaned. During observation with the surveyor of the central bath on the north wing, Staff A was showed the brown like discoloration on the floor of the shower stall and the soiled areas. Staff A stated that the brown discoloration looks like poop. Staff A stated that in this case, they should have called housekeeping to clean the bathroom. On 08/06/2020 at 10:35 AM Staff B, Licensed Practical Nurse (LPN) revealed, the residents had scheduled showers and housekeeping was responsible for cleaning the bathrooms. The CNAs are responsible for keeping the central bath clean between each resident. The central bath shower area should also be disinfected between residents. During an observation of the central bath/shower with the state surveyor, Staff B stated that the brown like discoloration on the floor looked like poop. Staff B stated ,This should not be like that. On 08/06/2020 at 11:01 AM Staff C, Housekeeping Aide reported that every day she cleans, used disinfectant with spray and then wiped the central bath in the mornings at 6:30 AM and at 2:00 PM. The surveyor discussed the identified concerns in the central bath/shower, Staff C revealed, she had not cleaned or disinfected the central bath during her shift. On 08/06/2020 at 11:09 AM the Housekeeping Director revealed, housekeeping should have cleaned and disinfected the central bath at 6:30 AM and between 9:30 AM to 10:00 AM, housekeeping disinfected and removed garbage and if needed, housekeeping would clean up the central bath. The Housekeeping Director stated that at around 1:00 PM to 2:00 PM, the central bath should be disinfected again. The Housekeeping Director observed the central bath with the surveyor. When the Housekeeping Director saw the conditions in shower stall for the central bath on the North wing, he stated the soiled areas on the floor looked like poop and that housekeeping was responsible for cleaning it up. The Housekeeping Director stated he would look for a housekeeping staff to clean central bath. On 08/06/2020 at 2:45 PM, the Director of Nursing (DON) and Staff K, Unit Manager revealed that the Housekeeping Director facility had a housekeeping log for the cleaning and disinfecting of the central baths. The CNAs were also responsible for keeping the central bath cleaned. In this case with the central bath being soiled, the CNAs are supposed to pick up the described brown like substance on the floor and call housekeeping to disinfect and clean. Observation of the Central bath at 2:56 PM accompanied by DON and Unit manager revealed, the central bath was still visibly soiled with brown like dislocation and matter on the floor. The DON and the Unit manager were informed by the surveyor that it has been almost four (4) hours since the observed visibly soiled shower room on the north wing was discussed and observed with nursing staff and the Housekeeping Director. The DON called the Housekeeping Director to have the central bath cleaned. Review of the facility's Cleaning Policy and Procedures, effective date 01/07, revealed that the facility should be cleaned and sanitized to provide a safe and pleasant environment.