STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105153	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PINECREST REHABILITATION CENTER	**13650 NE 3RD COURT NORTH MIAMI, FL 33161**

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 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** Based on observation, interview and record review the facility failed to promote resident's dignity and respect for one resident (Resident #51) out of one resident during dining. This practice has the potential to affect all 77 residents out of 95 residents who eat orally in the facility at the time of the survey. The findings included: Record review of Promoting/Maintaining Resident Dignity During Mealtimes Policy & Procedure (Date Implemented 1/2020) documented: Policy: It is the practice of this facility to treat each resident with respect and dignity and care for each resident in a manner and in an environment that maintains or enhance his or quality of life, recognizing each resident's individuality and protecting the rights or each resident. Policy Explanation and Compliance Guidelines: 1) All staff members involved in providing feeding assistance to residents promote and maintain resident dignity during mealtimes. Observation on 3/02/20 at 12:14 pm in the dining room showed both resident #48 and resident #51 seated at the dining table in their wheelchairs; there were no food trays in front of the residents. Observation on 3/02/20 at 12:16 pm showed Cart 1 was delivered in the dining room which contained lunch trays. Resident #48 lunch tray was on Cart 1. He was given his tray and proceeded to eat his lunch. Resident #51 did not receive a lunch tray. Resident #51 was not interviewable. Observation on 3/02/20 at 12:23 pm showed Cart 2 was delivered in the dining room which contained lunch trays. Observation on 3/02/20 at 12:31 pm showed Resident #51 received his lunch tray which was on Cart 2. He sat waiting at the table and did not receive his lunch tray until 15 minutes later after Resident #48. Interview with Staff A, Charge Nurse on 3/02/20 at 12:40 pm. She stated, He only has pleasure food. He feeds himself. Interview with the Registered Dietitian on 3/05/20 at 10:57 am. She stated, He is on pleasure foods, mechanical soft diet with thin liquid for lunch. He eats in the dining room for lunch. Review of Resident #51 Meal Ticket documented no table assignment, Diet Order-Mechanical Soft, Pleasure Foods, Thin Liquid and Pleasure Food lunch and PRN (as needed) only. Interview with the Certified Dietary Manager and Food and Nutritional Services Manager on 3/05/20 at 11:04 am. The Food and Nutritional Services Manager stated, The meals are served by tables and they are served together. His meal ticket does not have an assigned table. Interview with the Director of Nursing on 3/05/20 at 12:00 pm. She stated, The meals come out from the kitchen. All the residents at that table will be served and eat at the same time.
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 record review and interview, the facility failed to accurately code a Minimum Data Set (MDS) for: 1) for one (resident #91) out of three sampled residents for hospitalization s, and 2) for one (resident #43) out of five sampled residents for unnecessary medication review. There was a total of 95 residents present in the facility at the time of this survey. The findings included: 1). Record review of the facility's policy and procedures titled, Conducting an Accurate Resident Assessment, dated 10/2019, revealed, The purpose of this policy is to assure that all residents receive an accurate assessment, reflective of the resident's status at the time of the assessment, by staff qualified to assess relevant care areas. 'Accuracy of assessment' means that the appropriate, qualified health professionals correctly document the resident's medical, functional, and psychosocial problems status using the appropriate Resident Assessment Instrument (RAI) (i.e. comprehensive, quarterly, significant change in status).Whether the MDS assessments are manually completed, or computer generated following data entry, each individual assessor is responsible for certifying the accuracy of responses relative to the resident's condition and discharge or entry status. Record review of the medical facesheet for resident #91 revealed that the resident was admitted to the facility on [DATE], and discharged on [DATE]; the resident left the facility Against Medical Advice (AMA). Record review of the nurses' notes dated 02/12/2020 revealed that resident #91 left the facility with his brother to go to an appointment at the hospital; the resident was alert and oriented. Further review of the nurses' notes indicated that the resident returned in stable condition. Resident #91 stated that he wanted to leave the facility, and he was educated on the process of a proper discharge and of all the risks associated with leaving AMA. Resident #91 was encouraged to stay until the morning so his discharged could be organized; however, the resident insisted that he wanted to leave. The resident signed the AMA form and left the facility with all of his belongings. Record review of the medical record for resident #91 revealed that the against medical advice (AMA) Form was signed and dated 02/12/2020. Record review of the discharge MDS dated [DATE] revealed that resident #91 was discharged to an acute hospital. Interview with the MDS Coordinator Team on 03/04/2020 at 10:22 am revealed that the MDS was coded incorrectly; it should have been coded as other because they did not know where the resident went after he was AMA. 2). Record review of the physician's orders [REDACTED].#43 revealed that the resident was prescribed 20 milligrams (mg) of [MEDICATION NAME], an antidepressant, 0.5 mg of [MEDICATION NAME], an antianxiety medication, and 5 mg of [MEDICATION NAME], an antipsychotic medication; all [MEDICAL CONDITION] medications. Record review of the medication administration records (MARs) for the months of January 2020 to (NAME)2020 revealed that resident #43 received the [MEDICAL CONDITION] medications as ordered by the physician. Record review of the Annual Minimum Data Set ((MDS) dated [DATE] revealed that resident #43 was not coded as receiving any of the [MEDICAL CONDITION] medications during the 7 day look back period. Interview with the MDS Coordinating Team on 03/05/2020 at 9:37 am revealed that the MDS should have been coded to reflect the medications resident #43 received; it was data entry error.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that safety was maintained for one (resident #57) out of one sampled residents for accidents, as evidenced by resident having a cigarette lighter in their possession. There were a total of fourteen residents that smoked in the facility at the time of this survey. The Findings included: Record review of the facility's policy and procedures titled, Resident Smoking, dated 01/2017, revised 01/20/2020, revealed, This facility provides a safe and healthy environment for residents, visitors, and employees, including safety as related to smoking. Safety protections apply to smoking and non-smoking residents.Residents who smoke will be further assessed, using the Resident Safe Smoking Assessment, to determine whether or not supervision is required for smoking, or if resident is safe to smoke at all.If a resident or family member does not abide by the smoking policy or care plan (e.g. smoking materials are provided directly to the resident, smoking in non-smoking areas, does not wear protective gear), the plan of care may be revised to include additional measures such as room searches, prohibited smoking

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

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F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) or even discharge. Smoking materials of residents will be maintained by nursing staff and/or designee. Observation on 03/02/2020 at 9:34 am of the smoking patio revealed that there were no staff members present on the smoking patio. Further observation revealed a therapy staff member bringing another resident to the smoking patio, and asked the other residents that were present if they had a lighter so the resident could light his cigarette. Resident #57 reached into her purse and presented a lighter for the resident and staff lit the resident's cigarette. The resident took the lighter and put it back in her purse. Record review of the Annual Minimum Data Set ((MDS) dated [DATE] revealed that resident #57 had a score of 15 on the Brief Interview for Mental Status (BIMS) test indicating that she was not cognitively impaired, and coded for current tobacco use. Record review of the smoking assessments dated 04/24/2019 to 01/16/2020 revealed that resident #57 was assessed and reassessed for smoking. It was noted that the resident was safe to smoke without supervision. Further review of the smoking assessments revealed that resident #57 was a Level I Smoker; she understood the smoking policy, and was able to demonstrate safe smoking practices. Interview with resident #57 on 03/02/2020 at 9:53 am revealed that whenever she went to the patio to smoke her cigarettes, sometimes staff was on the patio, and sometimes they were not. For residents like herself that were cognitively intact, she did not need to be supervised while smoking; only the residents that were cognitively impaired needed to be supervised. Resident #57 reported that Social Services staff came and confiscated her lighter, and any other residents that had lighters. This was something new that they just started today, but before she kept her lighter in her possession. However, most of the time the residents' smoking materials were kept in the black cabinet that was located in the dining area. Observation and interview on 03/02/2020 at 12:40 pm revealed that in the smoking patio a staff member was present handing out cigarettes and lighters to two residents. Interview with the Activity Assistant (Staff C) revealed that she supervised the smoking patio from 7 am to 3 pm, and there was another staff that would come to the patio from 3 pm to 11 pm. Staff C stated that each resident that smoked cigarettes had their own basket with smoking materials such as cigarettes and lighters, which was kept in the cabinet in the dining area, and provided to the residents when they wanted to smoke. For Level 2 residents, they were provided aprons and their cigarettes needed to be clipped so they did not burn their hands. Observation and interview on 03/04/2020 at 7:38 am revealed resident #57 self-ambulating in her wheelchair past the lobby area. The resident stated that she was doing good, and that she was looking for someone who had not arrived yet. The resident was observed with a red lighter in her lap as she was passing by. Interview with the Licensed Practical Nurse (Staff B) on 03/04/2020 at 10:38 am revealed that social services completed the smoking assessments. Resident #57 was safe to smoke on her own, and she could hold a cigarette; the resident did not need supervision. There was a system in place where someone supervised the smoking area and provided smoking materials to the resident. Residents were not supposed to have lighters in their possession. Interview with the Social Services Assistant (Staff D) on 03/04/2020 at 10:44 am revealed that she completed smoking assessments; a Level I smoker was someone that could smoke safely without supervision, light their own cigarette, and put the cigarettes out themselves. A Level II smoker needed supervision, needed an apron, and needed assistance with lighting and putting out their cigarette. There usually was someone supervising the smoking area between 8:30 am to 5 pm, and they were currently looking to hire someone in the evenings. Smoking materials were kept in a locked cabinet, and each resident that smoked had their own basket with smoking materials in it. Residents were not supposed to have lighters in their possession. Staff D stated that they conducted rounds every morning and checked the residents for lighters and any extra cigarettes. The Social Services Assistant stated that she confiscated the lighters on 03/02/2020 and that when she made her rounds today and she did not see resident #57 with a lighter. Interview with the Director of Nursing (DON) on 03/04/2020 at 11:06 am revealed that a month ago, on 02/12/2020, they completed a sweep of the facility and confiscated any lighters that were found. Residents were educated on the new smoking policy and procedures, and if they violated the policy they could lose their smoking privileges. A resident council meeting was completed as well. The DON stated that lighters should not be in residents' possession and they were going to have to do another sweep of the facility.
F 0867 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.** Based on record review and interview, the facility failed to ensure an effective Quality Assessment and Assurance (QAA) committee as evidenced by not implementing corrective plans of action for correcting repeated deficiencies related to Minimum Data Set (MDS) coding accuracy. Cross reference of F641 for Accuracy of Assessments for resident #43 and resident #91. The facility had a citation for F641 for Accuracy of Assessments during the recertification survey in 2020. The Findings included: Record review of the facility's policy and procedures titled, Quality Assurance Committee and Performance Improvement, dated 01/2019, revised 01/2020, revealed, It is the policy of this facility to develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life.The QAA Committee shall be interdisciplinary and shall: Develop and implement appropriate plans of action to correct identified quality deficiencies. Record review of the Federal Provider History Profile Report revealed that the facility had deficiencies cited related to accuracy of assessments during the annual surveys conducted in 02/2016 and 03/21/2019. Interview on 03/05/20 at 3:30 pm with the Director of Clinical Services, Regional Nurse, Administrator, Director of Medical Records, Director of Nursing (DON), and Assistant Administrator revealed that in January 2020 it was identified that there were some coding errors with the MDS; one resident was identified, and then another resident was identified in February 2020. The Regional Nurse, the Administrator, and the DON had a call to discuss the findings and what sections to review. There was an MDS scrubber, which was a computer program that reviewed the MDS assessments for any inconsistencies such as medications without a diagnosis; the committee felt that the program was good and started it at the facility in February 2020. Quarterly reviews of the charts were completed as well. In (NAME)2019 or September 2019 staff were in-serviced on MDS coding. To eliminate repeated deficiencies in MDS assessments the committee had staff do training in coding and all of MDS coordinators in re-trained in October 2019. The committee felt that they made a good faith attempt to correct the deficiencies identified in the MDS assessments; however, the DON stated that she was going to provide additional training to MDS staff and conduct frequent audits as well.