STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105679	A. BUILDING _____ B. WING _____	03/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
REGENTS PARK OF SUNRISE	9711 W OAKLAND PARK BLVD SUNRISE, FL 33351

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 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** Based on observation and interview, it was determined that the facility failed to provide residents residing on B and C Wings housekeeping and maintenance services to maintain a sanitary, orderly, and comfortable interior, that included areas of, the dining room furniture, shower areas, hand rails, and floors. The findings included: 1. During numerous routine observations of the facility conducted of the facility throughout 03/10/20 and 03/11/20, it was noted that copious amounts of what appeared to be small, white, loose paint chips/specks/peelings noted as being just outside of the residents' room doorway entrance and trailing back inside to the entry way. During the environment observation tour conducted on 03/12/20 at 10 AM with the administrator, the following areas were noted to be affected: B - Wing: Hallway Rooms #100 - #111, hallway rooms #112 - 122, hallway rooms #123 - 132, nursing station area. C - Wing: Hallway rooms # 200 - 211, hallway rooms #212 - 223, hallway rooms #223 - 232. 2. During the observation of the lunch meal on 03/10/20 at 12 PM, the following issues were noted: (a) Observation of the B-Wing Dining Room noted that the exterior of the sofa and chair were heavily soiled and stained. It was also noted that exteriors of 6 of 6 dining room chairs were heavily worn, soiled, and stained. (b) Observation of the C-Wing Dining Room noted that exteriors of 4 of 4 dining room chairs were heavily worn, soiled, and stained. 3. During the observation of the B-Wing on 03/10/20 at 10:30 AM, it was noted that the exterior hallway handrails were stained and in disrepair that included exposed area of wood. The areas included the main hallway leading up to the unit, hallway including rooms #100 - 111, hallway including rooms #112 - 122, and hallway including rooms #123 - 132. 4. During the environment tour conducted on 03/12/20 at 10:45 AM accompanied with the administrator, it was noted that 9 resident wheelchairs (3 motorized, 6 high-back) were stored in the hallways outside of rooms. Further observation noted that the exteriors to all 9 wheelchairs were heavily soiled, stained, and had numerous large areas of dried food matter. 5. During an environmental tour of the facility, the following concerns were noted: a. At 10:54 AM on 03/10/20, during an investigation of the men's shower room on the B-Wing, there was found an opened bar of soap on the tray of the body wash/shampoo dispenser. The bar had worn spots that indicate the soap had been used. The toilet had a wad of toilet paper in it. The toilet failed to flush the toilet paper down the drain. There was a shower bed with a used wound dressing stuck to the frame. There was a heavy amount of black and grey dirt on and around the air-conditioning vent in the ceiling. The area near the sink was missing the paper towel dispenser. There was no way for a person to dry their hands. The call bell in the shower stall at the back of the shower room was difficult to activate, requiring a very hard tug to activate. b. At 10:59 AM on 03/10/20, during an investigation of the women's shower on the B-Wing, there was found dark, blackish dirt in the grout between floor tiles, dark brown spots on the grab bars of the showers, a heavy amount of black and grey dirt on and around the air-conditioning vent in the ceiling and in the first shower stall the emergency call bell was deactivated with screw threads placed in the spot where the cancel button would normally be found. c. At 11:18 AM on 03/10/20, further investigations revealed in the B-Wing Clean Utility room, there was a box of opened spoons that were subject to contamination. On the ceiling above the spoons, there was an air-conditioning vent with a large area of grayish dirt surrounding the vent. d. At 11:20 AM on 03/10/20, further investigations revealed in the B-Wing Dirty Utility room, the slop sink was stained with a yellow stain and black spots as well as the air-conditioning vent, which was covered with black and gray dirt. e. On 03/10/20 at 2:36 PM, accompanied by the Corporate Nurse For Clinical Services and the Director of Nursing (DON), they were shown the findings in the B-wing and continued to investigate the C-Wing. In the men's shower room, an observation was made on and around the toilet a large collection of water. When the toilet was flushed a copious flow of water came from a joint in the plumbing above the toilet. On the grab bars at the back of the last showers stall, there were dark brown spots of undetermined matter. The call bell cord in the far stall pulled out of the switch and the call bell did not activate. f. On the C-Wing in the women's shower, the call bell cords were extremely filthy starting at the point where one would normally grab the cord and continuing to the bottom of the cord. g. At 3:02 PM on 03/10/20, during the continued environmental tour in the dirty utility, there was a refrigerator, normally used for specimens, that was unplugged. The gasket on the door of the refrigerator was dirty with a heavy accumulation of dark black staining usually associated with mold. In the same room, there was a large trash cart with uncontained trash at the bottom. The air-conditioning vent was covered with an accumulation of gray and black dirt. These items were also observed by the DON and the Corporate Nurse For Clinical Services. The facility administrator was made aware of these finding. The facility administrator stated that she had started a Performance Improvement plan for the items described, however, the documentation provided did not contain enough details to satisfactorily explain the plan, identify goals and results, who was assigned the tasks and when the tasks were to be completed. (Photographic evidence was obtained).
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record reviews and interviews, the facility failed to implement a comprehensive care plan for 1 of 2 sampled residents on isolation (Resident #105), and failed to include physicians' orders in a [MEDICAL TREATMENT] care plan for one of one sampled resident for [MEDICAL TREATMENT] (Resident #36). The findings included: 1. During an observation conducted in Resident #105's room (isolation room) on 03/11/20 at 1:07 PM, it was noted that the resident was in bed and that the television (TV) was off. The resident on isolation. Review of Resident # 105's clinical record indicated an admitted to the facility of 11/15/19. On (NAME)2, 2020, the resident was placed on isolation related to [MEDICATION NAME] Due to [MEDICAL CONDITION], ([MEDICAL CONDITION]). Additional [DIAGNOSES REDACTED]. Bowel Disease. Review of the Minimum Data Set (MDS) Section C of the MDS, dated [DATE], indicated that Resident #105's cognitive ability could not be assessed, and the score obtained was 00/15, indicating severe cognitively impairment. Review of the Care Area Assessment (CAA) for Activities indicated that the resident preferred group activities. Additionally, due to the resident's lack of safety awareness a scoop mattress would be provided, the resident would be invited, encouraged, reminded and escorted to activity programs consistent with the resident's interest to enhance physical strengthening needs. However, based on the Resident's observed physical and reviewed medical status, Resident 105 was no longer able to attend group activities. The Activity plan of Care, dated 02/27/20, indicated that the resident required staff assistance with involvement of Activities related to behavioral symptoms that may affect participation, cognitive deficits. Resident #105 required physical assistance to and

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F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) from activities. The CP did not reflect that due to the resident being currently on contact isolation, her activities would be and were modified. There was no plan in place on how the facility would meet the resident's needs for activities while in isolation. The care plan did not indicate Resident 105's preference to watch or not watch TV, do puzzles and read as the Activity Director had informed. Review of the initial Activity assessment, dated 11/19/19, revealed that the resident preferred group activities, in room activities, general activities program, sitting outside; watching TV, and word puzzles. The record revealed that staff would escort the resident to activities and encourage participation as tolerated. The plan was not updated. During an interview with the Activity Director (AD) on 03/12/20 at 11:28 AM, she acknowledged the findings and agreed that the care plan needed to be modified in order to reflect Resident 105 current medical status. During an interview with the MDS Coordinator on 03/12/20 at 1:03 PM, he said that he did the Care Plan and that the Activity Director did the activity plan of care. He agreed with the findings. During the exit meeting on 03/13/20 at 3:50 PM, the Interim Administrator also acknowledged the findings and provided no additional information. 2. During the review of the clinical record of Resident #36 on 03/13/20, it was noted a re-admission date of [DATE]; and [DIAGNOSES REDACTED]. During the review of current physician orders, the following was noted: 01/27/20 - No Blood Pressure or Blood Draws of Left arm. 07/20/19 - [MEDICAL TREATMENT] Catheter Site - Monitor Every Shift for Signs and Symptoms of Infection. 07/20/19 - [MEDICAL TREATMENT] Shunt - Monitor Every Shift for Signs and Symptoms of Bleeding in Left Upper Arm. 07/20/19 - [MEDICAL TREATMENT] Arterio Venous (AV) Fistula - Monitor Every Shift for Bruit and Thrill in Left Upper Arm. A review of the current [MEDICAL TREATMENT] care plan, dated 01/14/20 for Resident #36 on 03/13/20, revealed that none of the documented approaches included the current physician's orders [REDACTED]. Interview with the MDS (minimum data set) Coordinator, on 03/13/20 to discuss the [MEDICAL TREATMENT] care plan, revealed that the current care plan of 01/14/20 was not updated to include the current physicians' orders.
F 0679 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide activities to meet all resident's needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and records review, the facility failed to provide ongoing activities for 1 of 2 sampled residents who were on isolation precautions, (Resident #105). The findings included: On 03/11/20 at 1:07 PM, an observation conducted in Resident #105's room (isolation room) revealed that she was in bed and that the television (TV) was off. The resident was on isolation precautions. Review of Resident # 105's clinical record indicated an admitted to the facility of 11/15/19. On (NAME)2, 2020, the resident was placed on isolation related to [MEDICATION NAME] Due to [MEDICAL CONDITION], ([MEDICAL CONDITION]). Additional [DIAGNOSES REDACTED]. Bowel Disease. Review of the Minimum Data Set (MDS) Section C of the MDS. dated 11/23/19, indicated that Resident #105's cognitive ability could not be assessed the score obtained was 00/15, indicating severe cognitive impairment. Review of the Care Area Assessment (CAA) for Activities indicated that the resident preferred group activities. Additionally, due to the resident's lack of safety awareness, a scoop mattress would be provided, the resident would be invited, encouraged, reminded and escorted to activity programs consistent with the resident's interest to enhance physical strengthening needs. The Activity Plan of Care (CP), dated 02/27/20, indicated that the resident required staff assistance with involvement of Activities related to behavioral symptoms that may affect participation, cognitive deficits. Resident #105 required physical assistance to and from activities. The CP did not reflect that due to the resident being currently on contact isolation that the plan was modified. There was no plan in place on how the facility would meet the resident's needs for activities while in isolation. The care plan had not been revised and did not indicate whether the resident had a preference to watch or not watch TV. Review of the initial Activity assessment, dated 11/19/19, revealed that the resident preferred group activities, in room activities, general activities program, sitting outside; watching TV, and word puzzles. The record revealed that staff would escort the resident to activities and encourage participation as tolerated. Observation conducted in the resident's room on 03/12/20 at 10:11 AM showed that Resident #105 was in bed covered. The TV was turned off. The TV remote control was observed on the resident's bedside table about 4 feet away from the resident's reach (photographic evidence retained). Review of the Nurses' Progress Notes (NP), dated 02/23/20, indicated that Resident #105 was observed in bed with bruise to right hip; The resident complained of pain; MD (physician) and family notified; and X-ray order received. On 02/29/20, NP (nurse practitioner) indicated that the resident is on isolation for [MEDICAL CONDITION]. On 03/04/20, the CNA (certified nursing assistant) reported the resident was observed with discoloration to the left side of her back and mid-back, skin intact with no discomfort voiced. The NP notes reflected that the resident's cognition level was intact (ability to respond to verbal command). As of 03/11/20, Resident #105 remained on isolation. In an interview with the Activity Director (AD) on 03/12/20 at 11:28 AM, she reported that she had seen the resident earlier that day and had turned on the TV for her. The AD said occasionally, she gave books to the resident. She said that the resident is able to read. She said Staff G, a certified nursing assistant (CNA), was in the room with her. The AD said that the resident is able to follow commands. She said that she talked to the resident about the resident's daughter, who resides at another facility and is disable. The AD said, when asked for evidence, that she does not document when she goes to the room. She advocated that she does a quarterly and annual report and she list the names of all the residents that she visits in the report. She also said that it would be impossible to document what she does with every single resident. Review of the 1:1 activity list provided to this writer did not have Resident #105, as one who would receive that service. The AD was then asked to review any documentation she made on any visitation with Resident #105. The AD indicated that she did not know how to review her documentation on the computer. After consulting with the Corporate Nurse (CN), the AD along with the CN, provided a computerized record indicating that activities were provided to Resident #105 in her room on 03/09/20 at 2:59 PM, on 03/10/20 at 2:59 PM, and 03/12/20 at 11:10 AM (television viewing). There was no other type of activities documented as provided on any other days. The resident's TV was turned on only three times from 02/29/20, from the date the resident was placed on isolation; or since 02/29/20. On 03/12/20 at 11:15 AM, the Resident's TV was noted to be off. This was a situation the AD could not clarify. She said that she did not know who turned the TV off. An interview was conducted with Staff-G, who the AD said went with her to Resident #105's room on 03/12/20 at 12:00 PM. She reported she works from 7:00 AM to 3:00 PM, but she did not work with the resident at all. She categorically refuted the claim that she even assisted anyone caring for Resident #105 on that day. During an interview with the Corporate Nurse on 03/12/20 12:33 PM, she said that the AD was not able to show where she documented the activity in the computer because she was nervous. The CN also agreed that the plan needed to be updated. During an interview with the MDS Coordinator on 03/12/20 at 1:03 PM, he said that he did the CP and that the AD needed to do the activity plan of care. He agreed with findings. During the exit meeting, the Interim Administrator also acknowledged the findings and provided no additional information.
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and review of policy and procedure, it was determined the facility failed to assess in following physician orders [REDACTED].#97). The findings included: Resident #97 was re-admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The resident had a Brief Interview Mental Status (BIMS) that indicated severely impaired, and never/rarely made decisions. A record review was conducted of the physician's orders [REDACTED]. During a [MEDICAL CONDITION] (trach) care observation conducted on 03/12/20 at 11:43 AM, Staff, A, a Registered Nurse (RN), was observed [MEDICAL CONDITION], suctioning of Resident#97, and changing the inner cannula and surrounding gauze pads. Staff A did not assess / do any of the following just prior to or after the procedure: 1) Check Resident#97's oxygen saturation level, 2) Assess the status of Resident#97's lung sounds and 3) Assess Resident#97's heart rate. On 03/12/20 at 12:08 PM, an interview was conducted with Staff A, in which she was asked if any of the following assessments were completed: oxygen saturation, lung sound assessment and assessment of heart rate just prior to and after [MEDICAL CONDITION] care. She acknowledged and admitted that she had not performed any of those assessment just prior to or after Resident #97's [MEDICAL CONDITION] care. She further stated that she did not even have her stethoscope on-hand with her. On 03/12/20 at 12:15 PM, an interview was conducted with Staff D, an (RN), Unit Manager B-wing and with the Director of Nursing (DON), in which they both acknowledged that the following assessments: oxygen saturation, lung sound assessment and assessment of heart rate, should have been completed on this resident just prior to and [MEDICAL CONDITION]. A record review was conducted of both the Medication Administration Record [REDACTED]. as needed, [MEDICAL CONDITION], mask and oxygen weekly as well as when needed, change oxygen tubing and set-up weekly, oxygen at 3 liters per minute [MEDICAL CONDITION] for shortness of breath. A record review of Resident #97's care plan, dated 06/07/19, revealed that it captured the following: Resident#97 has shortness of breath related to decreased lung expansion --staff to monitor /

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F 0695 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) document breathing patterns. Resident #97 with [MEDICAL CONDITION] in place related for impaired breathing --staff to monitor / document respiratory rate, depth and quality for clear bilateral breath sounds; and Resident #97 with altered respiratory status / difficulty breathing related to decreased lung expansion, [MEDICAL CONDITION] and [MEDICAL CONDITION] and Shortness of Breath --staff to monitor for signs / symptoms of respiratory distress .increase respirations, decreased pulse oximetry, increased heart rate ([MEDICAL CONDITION] and monitor / document / report abnormal breathing patterns decreased heart rate, use of accessory muscles, pursed-lip breathing or nasal flaring to avoid complications. During a computerized record review of Resident #97's reference sheet also revealed that Resident #97's oxygen saturation rate of: 97% was last recorded at: 10:35 AM, that morning and Resident #97's heart rate of: 100 beats per minute (bpm) was last recorded at: 9:41 AM, that morning. (Photographic evidence obtained). A record review was conducted of Staff A, an (RN)'s job description dated 01/27/20, which indicated that the Registered Nurse (RN) is responsible for delivering care to residents / patients utilizing the nursing process of assessment, planning, intervention, implementation and evaluation. Direct Care/Patient Responsibilities: Assesses, plans directs and evaluates total nursing care as determined by the residents/patients age related physical, psychological, and cultural needs in accordance with established standards, policies, procedures and resident's/patient's care plan .Maintains accurate, detailed reports and records .Monitors all aspects of resident's/patient's care .Performs physical examinations to determine the resident's/patient's status .Assesses the needs of residents/patients to identify potential health or safety problems. A record review was conducted of Staff A, an (RN)'s signed off and completed / required (RN) competencies dated 02/21/20, which indicated for Nursing Care to Residents Performs nursing care consistent with resident needs .Demonstrates knowledge and understanding of physical assessment as follows: Respiratory---breath sounds .heart sounds Types of delivery equipment for oxygen .Oxygen saturation machine. Review of facility policy and procedure on 03/12/20 at 1:30 PM for Tracheal Suction provided by the DON reviewed May 2017 indicated for .(Before) Procedure to perform respiratory assessment to include: heart rate, respiratory rate, breath sounds, cough effort and sputum production Repeat procedure until breath sounds are clear (After) Procedure to perform respiratory assessment to include: heart rate, respiratory rate, breath sounds, cough effort and sputum production.
F 0759 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure medication error rates are not 5 percent or greater.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and review of policy and procedure, it was determined that the facility failed to ensure that the resident's medication was given within the ordered parameters per physician order, during the Medication Administration Observation Pass for 1 of 9 sampled residents, Resident #55. The medication error rate was 7.69% (percent). Two medication errors were identified while observing a total of 26 opportunities, affecting Resident #55. The findings included: A Medication Administration Observation was conducted on 03/10/20 between the times of 4:18 PM and 4:32 PM for two (2) of four (4) medications for Resident #55 with Staff B, a Registered Nurse (RN) on the B-wing. Staff, B was observed pulling / preparing both of Resident #55's medications from Team/Cart 1 on B-wing: [MEDICATION NAME] HCL 200mg and [MEDICATION NAME] 10mg from their containers individually one-by-one. The resident had a physician order [REDACTED].<60 or Heart rate <60. The resident's (BP) reading was recorded by the nurse as: 142/49 pulse 68. The DBP reading of: 49 is less than the 60 reading, that was the ordered parameters by the physician. The [MEDICATION NAME] is ordered as: 10mg 1 tablet twice daily to hold for Systolic Blood Pressure (SBP) less than <100 or Diastolic Blood Pressure (DBP) less than <60 or Heart rate less than <60. The resident's (BP) reading was recorded by the nurse as: 142/49 pulse 68. The DBP reading of: 49 is less than the 60 reading, that was the ordered parameters by the physician. Resident #55 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The resident had a Brief Interview Mental Status (BIMS) score of 1, indicating moderate cognitive impairment (Photographic evidence obtained.) On 03/10/20 at 4:35 PM, during an interview, Staff B was observed checking and reviewing the computerized medication order and he admitted and agreed that he should not be giving this medication and that it should be held because the Diastolic (BP) reading was 49 and less than the parameter of 60, as ordered by the physician. Staff B stated to this surveyor that he was ready and prepared to give Resident #55's medications and proceeded to enter Resident #55's room and walk in the direction of the resident. The medications were not administered to the resident due to surveyor intervention. This surveyor asked Staff B for verification of Resident#55's (DBP) for both [MEDICATION NAME] and [MEDICATION NAME], outside of the resident 's room. On 03/10/20 at 4:41 PM, an interview was conducted with the Director of Nursing (DON) regarding the medications and she also agreed that neither of these medications should be given to the resident based upon the parameters ordered by the doctor. A record review was conducted of the physician's orders [REDACTED].<100 or Diastolic Blood Pressure (DBP) less than <60 or Heart rate less than <60 and [MEDICATION NAME] is ordered as: 10mg 1 tablet twice daily to hold for Systolic Blood Pressure (SBP) less than <100 or Diastolic Blood Pressure (DBP) less than <60 or Heart rate less than <60. A new order was obtained to adjust the parameters for the medications, after surveyor intervention. A record review was conducted of the Medication Administration Record [REDACTED]<100 or Diastolic Blood Pressure (DBP) less than <60 or Heart rate less than <60 and [MEDICATION NAME] is ordered as: 10mg 1 tablet twice daily to hold for Systolic Blood Pressure (SBP) less than <100 or Diastolic Blood Pressure (DBP) less than <60 or Heart rate less than <60. Review of facility policy and procedure on 03/11/20 at 11 AM for Physician order [REDACTED].Medications that require monitoring will need to be entered into the electronic medical record Confirm the accuracy of orders. Review orders daily in the clinical meeting to confirm accuracy in transcription and identify errors of omission.
F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** Based on observation and review with facility staff, the facility failed to properly secure medications in 2 of 3 medication carts on the C-Wing. The findings included: On 03/10/20 at 3:38 PM, during an environmental tour with the Director of Nursing (DON) and Regional Nurse Consultant, the medication carts for C wing were randomly checked to determine drawer security. On two of three medication carts, there were drawers that were openable even with the lock fully depressed (locked). These medication carts were checked several times with them being unlocked and relocked. The drawers continued to remain openable. At this time, the DON had the medication carts placed in the locked medication room for security. The nurses were instructed that they needed to have the carts watched when the nurse was performing medication administration and the carts needed to be locked in the medication room at times when medication administration was not in progress. The DON then contacted the supplier of the carts for a more permanent solution.
F 0803 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.** Based on observation, interview, and record review, it was determined that the facility failed to follow the entree portion of the approved facility menu. The findings included: During the observation of the lunch meal in the main kitchen on 03/12/20 at 11:50 AM, it was noted that Hawaiian Baked Ham was the main entree being served. During the observation, it was noted that 2 slices of the ham were being served as the standard portion of the entree. At the request of the surveyor, 2 random portions of the entree that were ready to be served to residents were weighed utilizing the facility's calibrated portion scale. The weighings were conducted by the Food Service Manager and both were recorded at 2.0 ounces. The weighings were also confirmed by the facility's Registered Dietitian. The Food Service Manager stated that a 3-ounce minimum portion, as per the approved menu, was to be served and that three slices of the ham should have been served to ensure a minimum 3 ounce portion. Following the weighings, a review of the approved menu for the lunch meal of 03/12/20 was conducted. The review revealed documentation that a minimum 3-ounce portion be served to residents receiving a Regular, No Added salt, and Carbohydrate Controlled Diet. A review of the facility's Diet Census for 03/12/20 revealed documentation that there were 70 residents with physician ordered Regular Diet, Carbohydrate Controlled Diet, and No Added Salt Diet, who could have ordered the ham entree on 03/12/20.

F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and review of policy and procedure, it was determined that the facility failed to ensure that it sanitized and disinfected the Blood Pressure (BP) cuff on B-wing after resident use for 1 of 1 resident observed during a Medication Administration Observation, (Resident #55); it failed to ensure that hand hygiene was practiced for 2 of 9 residents, during a Medication Administration Observation, (Resident #55 and Resident #68); it failed to ensure that it practiced appropriate infection control techniques during a peri-care observation for 1 of 1 resident observed for peri-care, (Resident #80); it failed to practice proper hand hygiene during a blood sugar test for 1 of 1 resident observed, (Resident #6); it failed to maintain Personal Protective Equipment (PPE) in the laundry room; and it failed to observe proper (PPE) protocol while answering a call light for a resident on transmission-based precautions (Resident#105). The findings included: 1. During a Medication Observation Administration on 03/10/20 at 4:10 PM, Staff B, a Registered Nurse (RN), was observed taking the 'plastic bagged' Blood Pressure (BP) cuff on B-wing into Resident#55's room and using it. After resident use, Staff B, an (RN) was then observed wheeling the (BP) cuff back out to the main corridor and left it there in the hallway, without first cleaning it and replacing it in its plastic baggie. 2. Resident #55 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. During a Medication Observation Administration on 03/10/20 at 4:18 PM, Staff B, an (RN), was observed entering Resident #55's room after having pulled / prepared the resident's four (4) medications and after touching the outside of the medication cart, Team/Cart 1 on B-wing, without first washing his hands again, just prior to going directly over to Resident #55 and administering her medications to her. 3. Resident #68, was re-admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. During a Medication Observation Administration on 03/10/20 at 4:47 PM, Staff B, an (RN), was observed entering Resident #68's room after having also pulled / prepared the resident's two (2) medications and after touching the outside of the medication cart, Team/Cart 1 on B-wing. Staff B, an (RN) failed to first wash his hands again, just prior to going directly over to Resident #68 and administering her medications to her. On 03/10/20 at 4:35 PM, during an interview, Staff B agreed that he should have cleaned and sanitized the (BP) cuff machine after resident use for Resident #55. He admitted that he did not wash his hands again after pulling both Resident#55 and Resident #68's medications and touching the outside of medication cart, Team/Cart 1 on the B-wing, prior to administering both of the residents' medications. On 03/10/20 at 4:41 PM, an interview was conducted

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REGENTS PARK OF SUNRISE	9711 W OAKLAND PARK BLVD SUNRISE, FL 33351

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 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) with the Director of Nursing (DON) regarding Staff B not cleaning the (BP) cuff after resident use and not washing his hands again prior to medication administration to both Resident #55 and Resident #68. The DON agreed that the (BP) cuff should have been cleaned and sanitized and the nurse should have washed his hands again prior to medication administration to both residents. 4. Resident #80 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Photographic evidence obtained. During a peri-care observation conducted on 03/12/20 at 11 AM, Staff C, a Certified Nursing Assistant (CNA), placed the dirty wash cloths that she had used to clean Resident #80's vaginal/peri-area and buttock area on the top outer edge of the towel-covered bedside table adjacent to the clean, unused linen (cross-contamination). These dirty, used exposed washcloths were allowed to come into contact with / brush-up against/touch Staff C's uniform jacket, as she walked back and forth next to the table while reaching across for incontinence care supplies. An interview was conducted with Staff C, on 03/12/20 at 11:08 AM, regarding the dirty washcloths touching the clean washcloths and her uniform touching the dirty washcloths. Staff C agreed that the cloths should not have been able to touch her uniform. She also agreed that the dirty washcloths should not have been allowed to come into contact with the other clean linen supplies. An interview was conducted with Staff D, a Registered Nurse (RN) Unit Manager for B-wing and with the Director of Nursing (DON) on 03/12/20 at 11:10 AM regarding the dirty washcloths touching the clean washcloths and Staff C, a (CNA)'s uniform touching the dirty washcloths. They also agreed that the uniform should not have been able to come into contact with the dirty wash cloths. They both further agreed that the dirty washcloths should not have been allowed to cross-contaminate with the clean linen. Review of facility policy and procedure on 03/12/20 at 1 PM for Equipment---Cleaning/Disinfecting, provided by the DON reviewed November 2017, indicated that the facility will take action to prevent resident care equipment and supplies from becoming sources of infection. Used equipment and supplies are considered contaminated with potentially infectious material and will be cleaned and disinfected as applicable before use with another resident Non-critical items that do not ordinarily touch the resident or items that touch only intact skin and require a low-level disinfection Blood pressure cuffs. Review of facility policy and procedure on 03/12/20 at 1:13 PM for Handwashing and Glove Use, provided by the DON reviewed November 2013, indicated that handwashing is a vital role in infection control reducing the surface microorganisms on our hands .Hands must be washed prior to beginning work .when working .following contact with unsanitary surfaces. 5. During the observation of the laundry department conducted on 03/10/20 at 10 AM and accompanied with the Regional Housekeeping Director, the following were noted: (a) During the observation of the soiled wash / sorting area, it was noted that there were no Personal Protection Equipment (PPE) visible in the room area. It was also noted that there were 3 carts full of soiled laundry and the 2 commercial washing machines were full and being utilized. Interview conducted with the laundry aide, at the time of the observation, revealed that she did know the Personal Protection Equipment was located in the wash room area; and it was unknown if the staff was utilizing PPE equipment on a daily basis. Following the interview, it was confirmed by the Director of Laundry/Housekeeping that there was no disposable PPE located within the laundry area. An interview conducted with the Director of Housekeeping / Laundry revealed that there are required par levels for disposable Personal Protection Equipment (PPE) for the laundry area. A review of the facility's Housekeeping & Laundry Policy and PPE Par Levels noted the following: Sorting Soiled laundry: 1 face Shield 1 Yellow Protective Gown 1 Rubber Gloves 1 Goggles Folding Clean Laundry: 2 Boxes Vinyl Gloves 2 Packs Yellow Disposable Gowns 1 Face Mask (b) Three of 3 laundry carts were noted to be stored in the clean folding area by Staff G. Further observation of the clean carts revealed that the bottoms had a buildup of a layer of dust, dirt and trash. Interview with Staff G revealed that the carts were not being cleaned and sanitized on a daily basis. 6. On 03/12/20 at 11:24 AM, an observation was made of Staff E, a Registered Nurse (RN), who was performing a blood glucose test for Resident #6. This is a routine, minorly invasive procedure done for diabetics before meals. Staff E washed her hands and put on gloves. Staff E then proceeded to disinfect the glucometer, a machine that reads a small sample of blood to test for blood glucose levels. Staff E wiped the glucometer for 2 minutes (timed) and allowed it to air dry. This was an acceptable way to disinfect the glucometer. The glucometer was placed on a barrier tray on the medication cart. The nurse then went to the resident's room, with the glucometer on the tray, where she explained the procedure to the resident to prepare the resident for the procedure. Staff E then washed her hands and returned to the medication cart with the glucometer. Staff E checked the orders and sanitized her hands. Staff E then prepared a disposable barrier tray with two medication cups into which she placed two lancets, which are devices to prick the finger to get a blood sample, and separately placed two test strips. Staff E then prepared to alcohol pads on the barrier tray. Staff E then went to the resident's room and placed her supplies on the over-bed table. Staff E wheeled the table to the bathroom, where she washed her hands while observing the table. Staff E then used her hands to move the table back to alongside the resident's bed. Staff E then used her hands to draw the privacy curtain. At this point, Staff E had touched two dirty objects. Staff E then proceeded to put on gloves, without re-washing her hands, to perform her task. The rest of the procedure was done without error. Staff E then removed her gloves and washed her hands. When questioned about the breaks in hand hygiene, Staff E did not immediately recognize her errors. When the breaks were explained, she then realized her mistakes. At 03/12/20 on 11:58 AM, the Director of Nursing (DON) was informed of the breaks in infection control. The DON acknowledged the breaks and agreed that theses lapses in infection control need to be addressed with staff. 7. On 03/10/20 at about 10:05 AM during a tour of the facility, it was observed that room [ROOM NUMBER] (private) had PPE equipment placed at the door. There was no disposable basket placed by the door. A few minutes following that observation, the nurse on duty was observed placing a box with a red plastic bag at the door. On 03/11/20 at 2:09 PM, Resident #105, who was placed on isolation, was observed in bed lying in [MEDICATION NAME] position on the bed. This writer immediately activated the Resident's call light for staff assistance. A few minutes later, Employee H entered Resident 105's room without wearing any protective apparel and turned off the call light without wearing any gloves. During an interview with Employee H on 03/13/20 at 11:40 AM, she reported that when someone is on isolation, employees must ensure that the personal protective equipment (PPE) are placed at the door and everyone entering the room (especially those who will provide care) must wear protective gear before entering the room. She also reported that everyone who enters the room and touches anything must wash their hands thoroughly and dispose of the PPE as they leave the room. She indicated that no one must touch anything with their bare hands.