STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105709	A. BUILDING _____ B. WING _____	**09/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NSPIRE HEALTHCARE MIAMI LAKES	**5725 NW 186 STREET HIALEAH, FL 33015**

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 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to report an incident related to an injury of unknown origin, and allegations of suspected abuse to the appropriate State agencies for one (Resident #1) out of three sampled residents. As evidenced by, Resident #1 was noted with injuries of unknown origin that included bruising and a skin tear above the right eye. 2) The facility's staff failed to report an allegation related to possible resident to resident altercation. There were 39 residents residing in the facility at the time of the survey. The findings include: Record review of the facility's Policies and Procedures, with a revision date of 11/28/2017, revealed: It is inherent in the nature and dignity of each resident at the center that he/she be afforded basic human rights, including the right to be free from abuse, neglect, mistreatment, exploitation and/or misappropriation of property. The document further showed that any employee who witnesses or has knowledge of an act of abuse or an allegation of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, to a resident, is obligated to report such information immediately, but no later than 2 hours after the allegation is made, if the events that caused the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the Administrator and to other officials in accordance with State law. The Abuse Coordinator of the company will refer any or all incidents and reports of resident abuse to the appropriate state agencies. Review of clinical records revealed Resident #1 was admitted to the facility on [DATE] and discharged on [DATE]. Clinical [DIAGNOSES REDACTED]. Review of the discharge Minimum Data Set (MDS) for Resident #1 dated 08/27/2020, Section C - Cognitive Patterns revealed Brief Interview for Mental Status (BIMS) score of 8 out of 15 indicating Resident #1 is moderately impaired. In Section G- Functional status, Resident #1 required limited assistance for bed mobility, transfer, walking in the room and walking in the corridor. For Section E- Behavior, the resident had no Physical Behavior. Wandering -Presence & frequency was coded as (0) indicating Behavior not exhibited. Review of the nursing progress notes dated 08/24/2020 indicated : during rounds patient noted with bruising to right eye and skin tear above right eye. Assessment done patient in stable condition. Patient is confused verbally responsive denied pain upon assessment. Review of the skin event report for Resident #1 dated 8/24/2020, time stamped 4:00 AM, revealed Resident #1 was noted with bruising to the right eye and a skin tear above the right eye.The document also indicated that the family and the doctor were notified at 6:35 AM. The document noted possible causative factor as confusion and that the event was added to the facility's 24-hour report. Review of the facility's abuse, adverse and reporting tracking log for August 2020 revealed no information related to Resident#1. Review of nursing notes for Resident #1 revealed, Staff D, a Licensed Practical Nurse (LPN) documented on 08/24/2020 that, at start of 7:00 PM shift, the off going nurse reported that Resident #1 was noted walking out of his room onto the hallway and was redirected back to his room by staff. Patient noted confused and very forgetful. At 9:00 PM while passing medications, patient attempted to get out of his bed, was walking around his room and outside his room on the hallway several times and was redirected each time .The entire shift patient was sleeping on and off and walking around. At 4:00 AM patient was noted in bed with bruising to right eye and skin tear above right eye. The patient was asked what happened, the patient stated nothing. Review of documentation completed by the Unit Manager on 08/24/2020 revealed, during morning care Resident #1 was observed with bruises around his eyes. When the resident was asked what happened, the resident stated, I bumped myself when I walk. On 09/21/2020 at 1:24 PM, Staff A, Registered Nurse, (RN) revealed during a telephone interview that he had overheard that Resident #1 got the bruising on his eye because he jumped another resident. Staff A stated that, he was not sure if Resident #1 jumped another resident or if another resident jumped resident #1 because it occurred on another shift. Staff A stated that he heard that something happened, but he did not know exactly what happened and when because he was off on that day. On 09/21/2020 at 1:51 PM the Administrator, Director of Nursing (DON), Assistant of Director of Nursing (ADON) and Vice President of Clinical Services (VPCS) were informed of the possible allegation of abuse related to Resident #1's injuries based on the interview with Staff A. During the interview with the Administrator, DON, ADON and VPCS, the surveyor was informed that Resident #1 was able to ambulate, would go into other resident's room and had to be redirected a couple times. When the nurse asked Resident #1 about the bruises, Resident #1 said nothing happened and that he bumped his head. The DON stated that Resident #1 was on blood thinner and a part of COVID-19 is increased bruises. The DON stated that when the nurse and the Certified Nursing Assistant (CNA) were called they stated that nothing happened. The Administrator stated that the facility did an investigation related to this incident and the conclusion of the investigation would be provided. On 09/21/2020 at 2:16 PM, Staff B, a Certified Nursing Assistant (CNA) revealed that she remembered resident #1 always left his bed and urinated inside the closet. Staff B reported that Resident #1 was a little resistant when asked to stay seated. Staff B also reported that Resident #1 ambulated to other resident's rooms, but was not aggressive with other residents and recalled an incident that occurred when Resident # 1 went inside a room occupied by women. Staff B revealed noting that Resident #1 had bruises on his eyes at the beginning of her shift on 08/24/2020 at 7:00 AM. Staff B stated that she reported the injuries to the nurse in charge and the nurse stated that they knew about it. Staff B stated that she did not know what happened on the day that Resident #1 got hurt. On 09/21/2020 at 3:50 PM, the Unit Manager revealed that she did not know what happened with resident #1. The Unit Manager reported that she asked the nurse and the patient what happened and the patient stated that he bumped himself. On 09/21/2020 at 5:36 PM, Staff D, RN revealed that she remembered Resident #1. Staff D reported that Resident #1 was a confused and an alert patient that ambulated in the hallway. Staff D stated that the CNA reported that Resident #1 had a bruise that was noted while the CNA was providing care. Staff D, stated that when Resident #1 was asked what happened, Resident #1 stated he did not know. Staff D stated that Resident #1 walked around during the night, slept a little bit and was forgetful. Staff D stated that she did not think Resident #1 was able to state what happened. Staff D reported that the facility does not have a supervisor at night and in the morning, they gave report to each other and the DON was made aware of the injury. Review of the Agency for Healthcare Administration (AHCA) Nursing Home Status Reporting Log did not indicate any report submitted by the facility related to Resident #1.

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