STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105680	A. BUILDING _____ B. WING _____	**08/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NSPIRE HEALTHCARE LAUDERHILL	**2599 NW 55TH AVE LAUDERHILL, FL 33313**

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 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to complete a thorough investigation and maintain documentation for 1 of 3 sampled residents, Resident #2, reviewed for falls, as evidenced by the lack of documentation related to witness staff statement and the lack of documentation related to in-services to be provided as per facility corrective actions plan. The findings included: Review of Resident #2 medical record documented an admission to the facility on [DATE], a re-admission on 11/01/19 and a discharge on 05/22/20. Review of the resident's care plan initiated on 09/26/19 and revised on 03/02/20 documented the resident is at risk for further fall related to .gait/balance problems . Review of the resident's care plan initiated on 03/02/20 documented 02/29/20 the resident has had an actual fall with minor injury, hematoma and discoloration to face and swelling to nose bridge. Residents [DIAGNOSES REDACTED]. On 08/12/20 at 10:00 AM, an interview was conducted with the facility's Minimum Data Set (MDS) Coordinator. The review revealed the resident's care plan was updated on 02/29/20. During an interview, the MDS coordinator stated that Resident #2 had a fall on 02/29/20 and new interventions were added and implemented. She stated that Resident #2 was not able to get out of bed by herself and needed two people for transfers. Review of Resident #2's nursing notes dated 02/29/20 documented resident was brought to the nurses' station by the aide to show and report hematoma and discoloration to forehead and discoloration and swelling to nose bridge. It's unknown how resident acquired injuries .resident could only shrug her shoulders to say that she doesn't know . On 08/12/20 at 1:45 PM, an interview with the Director of Nursing (DON) was conducted. She stated that Resident #2 was a long-term care resident. A side by side of the facility's incident investigation documentation was conducted with the DON. The review revealed that Staff K, a Certified Nursing Assistant, documented that on 02/28/20 around 7:00 PM, she was called to assist Staff J, a Certified Nursing Assistant, to put Resident #2 in bed and found resident sitting on the floor, no bruises, no skin tear noted at the time. Review of Staff L, a Registered Nurse statement documented that she worked on 02/28/20 the second shift and no report was given to her regarding Resident #2's fall. The DON stated that upon her investigation related to Resident #2 and discoloration of her forehead and swelling nose, she contacted Staff J who was assigned to the resident on 02/28/20 and Staff J told her that she forgot to report the incident to the nurse. The DON stated that Staff J reported that Resident #2 slipped and hit her face on the foot board of her bed. The DON states that Staff J was reprimanded and suspended. The DON stated that Staff J is not available for an interview. During the review, the DON was asked to present evidence of Staff-G fall witness statement and was not able to present one during the survey. The DON was asked to submit documentation related to education provided to the staff as stated on the five days reporting. On 08/12/20 at 2:30 PM, the facility's Assistant Director of Nursing (ADON) was asked to submit a copy of Resident #2's nursing notes and skin assessment/body audit tool for 02/28/20 and 02/29/20. Also, on 08/12/20 at 3:30 PM, the ADON was asked to submit a copy of the facility's policy on Residents incident reports and reporting timeframe. Review of the policy did not document reporting timeframe's. On 08/12/20 at 3:45 PM, the facility's ADON was asked for the notes again and did not have them, he was asked to fax a copy of Resident #2 nursing notes and skin assessment/body audit tool for 02/28/20 and 02/29/20. On 08/12/20 at 3:45 PM, the DON provided a copy of attendance sheet for in-services on Adequate Supervision dated 01/02/20; 02/10/20 and 02/13/20. Review of such documents revealed that neither Staff G nor Staff H were on attendance. The DON was asked for in-services after Resident #2's fall investigation on 02/29/20 and stated that she could not find any attendance sheets for those in-services. The DON was apprised regarding the lack of documentation related to Resident #2's fall investigation and the lack of the facility's action plan documentation related to in-services to the staff involved.
F 0636 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record reviews, the facility failed to do a quarterly review assessment for nutrition for 2 of 2 sampled residents reviewed (Resident #1 and Resident #3) for weight loss as evidenced by no quarterly assessments available for review. The findings included: 1. Record review of Resident #1 showed that he was admitted to the facility on [DATE]. Further review showed that Resident #1 had a nutrition quarterly review on 09/24/19. There was no other nutrition assessment done until 05/16/20. Resident #1 should have had a quarterly assessment completed in December 2019 and March 2020. In an interview with the Clinical Dietitian on 08/11/20 at 2:00 PM, she reported that she was not here during that time and was not sure as to why it was missed. She further acknowledged that the quarterly nutrition assessment was not done in a timely manner. In an interview conducted on 08/12/20 at 9:37 AM with the Minimum Data Set Coordinator, she reported that all nutrition quarterly reviews are done under the progress notes section. According to her, there were two quarterly assessments completed on 10/05/19 and 03/05/20. She further acknowledged that the quarterly assessments for nutrition were not done. 2. Review of records showed that Resident #3 was admitted on [DATE]. Nutrition progress notes showed that Resident #3 had a quarterly review note on 09/19/19 and did not have another follow up quarterly review until 04/26/20. Further review of the care plan showed that the nutrition focus was not revisited until 08/11/20 by the current Dietitian. Review of the recorded weights showed that on 01/13/20, Resident #3's weight was 136.6 pounds and on 08/04/20, the weight went down to 104 pounds. In an interview with the Clinical Dietitian on 08/11/20 at 2:00 PM, she reported that she was not here during that time and was not sure as to why it was missed. She further acknowledged that the quarterly nutrition assessment was not done.
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 observations, interviews and record reviews, the facility failed to provide adequate supervision to ensure resident safety for 2 of 3 sampled residents reviewed for supervision, Resident #1 and Resident #2, as evidenced by failing to reassess for elopement risk, resulting in Resident #1 eloping from the facility; and failing to adequately supervise Resident #2 resulting in an elopement from the facility and sustaining injuries. The findings included: 1. Resident #1 was admitted to the facility on [DATE] from a 12-day hospital stay with [DIAGNOSES REDACTED]. Resident #1 was admitted to the skilled nursing facility to recover from the COVID-19 virus. Prior to the hospital stay, Resident #1 was living at home with family. Review of the Initial Nursing assessment dated [DATE] documents Resident #1 was alert to person. Resident #1 was able to ambulate independently without any assistive devices. Further review of the Initial Nursing Assessment electronic paperwork revealed the Elopement Risk Evaluation Assessment had not been completed on admission on 06/09/20 and was blank. Review of the facility policy for Elopement/Wandering Risk states in part, 'To evaluate and identify residents

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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 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) that are at risk for elopement and develop individualized interventions Residents to be evaluated on admission.' Review of the Minimum Data Set (MDS) Admission assessment dated [DATE] documented Resident #1 had a BIMS (Brief Interview for Mental Status) score of 3, indicating severe cognitive deficit. Review of a Nursing Progress Note revealed a Late Entry written by a Licensed Practical Nurse (LPN) night charge nurse, dated 07/29/20 at 4:41 AM, stating 'Upon rounds noted resident not in bed. Staff began search for resident on units. Unable to locate. Code purple (resident elopement) activated. Inside and outside of facility searched. 911 called. Family, Director of Nurses (DON), and physician notified of resident status. Resident was last seen by staff in room at approximately 3:30 AM.' Review of the facility Timeline documentation revealed the local police were contacted on 07/29/20 at 4:41 AM to notify and alert them of the missing resident. In a Nursing Progress Note dated 07/29/20 at 7:48 AM, the DON documented, 'Received call from (name of hospital) ER (emergency room) approximately 6:50 AM stating resident was in the ER whom was brought there by police.' Review of a Nursing Progress Note dated 07/29/20 at 10:30 AM, documents, 'Resident returned to facility alert and able to make needs know. Head to toe assessment done. Resident is able to ambulate without assistance.' Review of the facility Timeline documentation revealed on 07/29/20 at 1:14 PM, the Director of Admissions called (name of hospital) and spoke with the ER charge nurse to inquire about the hospital paperwork for the resident. Per ER charge nurse, resident was found wandering in the street and was brought in by the police. On 08/11/20 at 2:47 PM, a tour of the North wing commenced. To the right of the nursing station behind closed double fire doors are the 300's rooms down that hallway and to the left of the nursing station behind closed double fire doors is the 400's rooms down that hallway. The one nursing station in the middle services both halls. On 08/11/20 at 2:50 PM, an interview was conducted with LPN (licensed practical nurse) Staff 'A' who works on the North unit 400's hallway where Resident #1 resided. The North unit 400's resident population is primarily residents with moderate to severe cognitive impairment and dementia. Resident #1's room was the first room to the right upon entry through the closed double fire doors. At the far end of the hallway is the glass outside exit door. An inquiry was made to LPN Staff 'A' how Resident #1 managed to walk all the way down this hallway and exit out the door at 3:30 AM without anyone noticing him leaving. LPN Staff 'A' stated she was not working that shift, but was told there was an admission from the hospital that came in and the exit door was not closed properly when the transporters brought the new admission in, so they think he just walked out. She further stated the door has been fixed so it will alarm if it is left open. A request was made to LPN Staff 'A' to exit through the door. She proceeded to enter a code into the touch pad on the wall and the door unlocked and alarmed until it was closed. On the outside of the door was a sign saying 24-hour video surveillance. An inquiry was made to LPN Staff 'A' where this video is kept to which she stated she thinks it is in the maintenance director's office. Observation made outside of the door, to the left were 2 trash dumpsters, the back parking lot with a driveway leading to a side 2-lane residential road. To the right of the doors was a vast expanse of rolling lawn wrapping all around the right of the building and beyond the grass led to a 2 lane thoroughfare. The 2-lane thoroughfare leads to a 6 lane busy main road and an overpass bridge. During the interview and observations with LPN Staff 'A', 4 female residents were observed to be wandering up and down the 400's hallway, 2 of which were observed trying to push down on the exit door bar attempting to exit through the door. An alarm was noted to be going off. LPN Staff 'A' stated these residents are constantly wandering and require the use of a wanderguard on their ankle which will set off an alarm if they get too close to the exit door. Review of the facility Admission Log for 07/29/20 revealed a resident was admitted to the facility from a hospital to room [ROOM NUMBER] at 3:11 AM. On 08/11/20 at 12:02 PM, an interview was conducted with the Social Worker (SW) who stated she found out about the incident that morning and Resident #1 tried to elope and he succeeded. The SW stated she does not know any details and to speak to the DON, as she was the person who was called into the building and took care of things. An inquiry was made of Resident #1's cognitive status to which she stated he was confused but when she spoke to him that morning, he said he was alright and just said I just want to go home. On 08/11/20 at 3:25 PM, an interview was conducted with the Director of Maintenance who stated the video TV monitor is in his office and the tape is kept for 4 days and then re-taped over. An inquiry was made if anyone looked at the video footage when the resident eloped, to which he stated he did not think so. An inquiry was made about his log for checking door alarms and he stated it is entered electronically on a tracking system. He stated the more recent logs are with the DON after the elopement, and he now checks the door alarms daily, stating he used to check them weekly. On 08/12/20 at approximately 2:15 PM, an interview was conducted with the DON inquiring about the events surrounding the elopement of Resident #1. An inquiry was made what was the resident wearing if he was last observed at 3:30 AM to which she stated she was not sure but thinks he had clothes on. An inquiry was made what time, where and by whom was he located off the facility property to which she stated a police officer saw him and thought he must be from a nursing home with the arm band and picked him up and took him to (name of hospital). She stated she does not think he was out there for a very long time as they noticed he was not in his room at 3:30 AM, they called the police after 4:00 AM and then got a call from (name of hospital) that the resident was there. The DON was unable to provide any specifics on how long the resident was missing from the facility, where the resident was found by the police or what time he was found by the police. Of note, the facility is located on a 2-lane road which intersects with a 6 lane busy main road and an overpass bridge which is located a few blocks to the north of the facility. A further inquiry was made how Resident #1 was able to exit the building to which she stated a new admission was brought in around 3:00 AM and Resident #1 just walked out the door. She stated when the transporters came in, the door did not shut completely behind them and the staff did not check to see if the door was closed completely. The DON stated now the door has been fixed, the code changed and maintenance is checking daily now instead of weekly. The resident census on the North unit was reviewed revealing on 07/28/20 between the 300's hallway and 400's hallway the census was 43. The staffing schedule was reviewed with the DON at this time and an inquiry made how do staff supervise residents on the night shift with 3 CNAs (Certified Nursing Assistants) and 2 licensed nurses on duty to cover the 300 and 400 hallways which are separated by the nursing station and cordoned off by double fire doors to which the DON stated they always have 3 aides on the night shift. A concern was raised if there are 3 CNAs on nights with 2 double doors closed off to the nursing station and if one aide was at the nursing station or assisting with an admission on the 400's hall at 3:00 AM and 2 aides were with residents on the 300's hall separated by the double fire doors, who is supervising or monitoring the residents on the 400's hallway. The DON had no comment. An inquiry was made to the DON what preventative measures have been put in place to address Resident #1's elopement to which she stated they fixed the door and the alarm goes off and maintenance checks the doors daily and the nurses have to check the alarms every shift. A request was made to review the alarm check log to which the DON stated the nurses are doing it but are not documenting they are doing it. Review of the night shift staffing assignments from 07/29/20 forward revealed the North unit is being staffed with 3 CNAs and 2 licensed nurses. The DON stated they have not considered increasing the staffing. A further inquiry was made to the DON if she viewed the video surveillance of Resident #1 eloping from the facility on 07/29/20 to which she stated she did not review the video tape, further stating the monitor is in the maintenance office and she does not have a key so she would have had to call the maintenance to come in to open the door. The DON was asked, if Resident #1 was last observed at 3:30 AM, what was he doing up at that time of the morning and what did the staff do about him being up at that time. The DON stated that is what residents do when they have dementia, they walk around all the time, especially at nighttime. The DON further stated she recalled 2 days prior the Activities Director assisted with a face time call between Resident #1 and his family and he wanted to see his family and missed them. The DON stated she did not know if he said to them that he wanted to go home. On 08/12/20 at 2:20 PM, an interview was conducted with the Activities Director who stated she arranged a face time call with Resident #1 and his daughter 2 days prior to him eloping. She stated he said he missed her, he wants to go home and how long is it going to take. She stated the daughter explained the process, and he kept saying he is waiting and wants to go home. The Activities Director stated she believed Resident #1 lived with them. An inquiry was made if she notified anyone of the Resident #1's persistent responses to his daughter about his desire to go home and she stated she had not. Review of Resident #1's clinical record revealed an elopement risk assessment was not completed on admission and an elopement risk assessment was not completed after the face time call when Resident #1 expressed he wanted to go home and who is ambulatory with a BIMS score of 3. On 08/12/20 at approximately 1:30 PM, a request was made to the DON and ADON (Assistant Director of Nursing) for the facility policy for Resident Supervision and Elopement Risk. The DON stated the Elopement policy is in the adverse incident investigation binder for Resident #1. A copy was obtained. The ADON stated he will look for the Resident Supervision policy. Re-review of the facility Elopement/Wandering Risk policy states in part, 'To evaluate and identify residents that are at risk for elopement and develop individualized interventions . Residents to be evaluated with a significant change in condition If resident is identified as being at risk complete an Elopement Risk Alert.' Review of the clinical record for Resident #1 revealed he had an ankle wanderguard bracelet applied on 07/29/20 after his return from the hospital and after eloping from

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) the facility at approximately 3:30 AM on 07/29/20. On 08/12/20 at approximately 2:30 PM, a second request was made to the ADON for the facility policy for Resident Supervision. He stated he is looking for it. On 08/12/20 at approximately 3:30 PM, a third request was made to the ADON for the facility policy for Resident Supervision. He stated he is looking for it. On 08/12/20 at approximately 4:00 PM during the exit conference with the Administrator, DON, ADON and Activity Director, a request was made to have the Resident Supervision policy forwarded to this surveyor electronically if they were still unable to locate the policy. The ADON acknowledged this and stated he will email the policy when found. As of 08/14/20, a Resident Supervision policy was not provided electronically, and no communication was received either electronically or by telephone from the facility regarding any policies. 2. Resident #2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Initial Nursing assessment dated [DATE] documented Resident #2 was awake, alert, oriented, verbally appropriate and was able to ambulate independently without any assistive devices. Further review of the Initial Nursing Assessment paperwork revealed an Elopement Risk Evaluation Assessment completed on admission on 07/14/20 at 4:50 AM, documenting Resident #2 as not a risk for elopement. Further review of the clinical record revealed no further Elopement Risk Evaluation Assessments conducted since the initial assessment conducted on 07/14/20 at 4:50 AM during the residents' admission to the facility. Review of the MDS Admission assessment dated [DATE] documented Resident #2 had a BIMS score of 7, indicating severe cognitive deficit per the guidance used by the facility for BIMS results interpretation, indicating a BIMS score between 0-7 is interpreted as Severe Cognitive Impact. Review of a facility Investigative Report revealed on 08/02/20, Resident #2 broke the window in his room and eloped from the facility through the broken window. Review of a witness statement from a Certified Nursing Assistant documented in part, 'On 08/02/20 at 8:20 PM I give care to Resident #2 and leave him in bed at 8:30 PM. (Name of person) call me to help her with a resident. After coming 8:48 PM I see the call light and I go check to see how I can assist at (room number). His roommate tell me that he heard a big bang next to him. I check and see that the window broken and a white blanket sit on the window. I run out and start calling code purple. Everyone come together and start looking in and outside. (Name of person) and get in her car and I go with her and we drive around 56 and 55 (roads next to the facility) we did not find him. We come back to the facility then me and nurse walk, go across the complex and start looking and ask anyone we see, we did not find him. We went back to the facility.' Review of a Nursing Progress Note dated 08/03/20 at 12:19 AM, the LPN documented 'Writer was notified by nursing aide who was assigned to patient. She states He used a sheet to put over his head it seemed and he broke the window and left. Blood is on the floor outside and in the room he left. I saw the call light and answered. When I entered the room, the roommate told me that he heard a loud bang. When I looked, I saw the window broken, I searched the bathroom and the rest of the room to see if he was there and he was not. Code purple was called twice. The facility was searched extensive inside and outside. 911 was called at 9:06 PM and rescue arrived around 9:15 PM. Supervisor made aware. Last time patient was seen he was not combative just casually walking the hallway. He was given water by writer and was given a chair to sit on. He was later found at 10 PM by the police and was taken to (name of trauma hospital) . Hospital called numerous times to follow up with status of patient. Patient is admitted to (name of trauma hospital) and sustained wound to forehead and left arm as per (hospital) nurse reported.' Review of a Nursing Progress Note completed by the DON on 08/03/20 at 2:30 PM documents, 'Spoke with Registered Nurse (RN) from (name of trauma hospital). According to RN CT scan of chest, CT scan of abdomen/pelvis, CT scan of brain, CT scan of face, CT scan of cervical spine done. No fracture or dislocation. Review of the partial hospital record for Resident #2 revealed vital sign documentation is timed at 10:53 PM indicating he arrived to the hospital somewhere around 10:50 PM via police and ambulance transport. Resident #2's hospital [DIAGNOSES REDACTED]. Review of a statement obtained by the facility from Resident #2's roommate dated 08/03/20 states in part, 'In the evening when it was dark outside I heard a knocking sound from my roommates side of the room and asked him what he was doing but he did not answer then I heard a loud crash and called out to him but there was no answer. I knocked on the wall and pressed the call light. The CNA (Certified Nursing Assistant) came into the room [ROOM NUMBER] minutes later and asked me if my roommate went into the hall, I told the CNA no. This happened yesterday 08/02/20.' On 08/11/20 at 2:50 PM, an interview was conducted with LPN Staff 'A' in the room Resident #2 broke the window and eloped from the facility. The window was observed to have been replaced. Outside the window were large and small shards of glass remaining on the dirt and grass on the ground. LPN Staff 'A' stated when she arrived that morning there was plywood covering the window. She stated they do not know how he broke the window but are thinking he put a sheet over his head and used his head to break the window. She stated she is not sure if anyone else heard the window shattering, but it was the roommate who called for the aide to come to the room. Review of the clinical record for Resident #2's roommate revealed an Admission MDS assessment conducted on 07/23/20 documenting his BIMS score to be a 15, intact cognitive response. On 08/12/20 at 12:00 PM, an interview was conducted with Resident #2's roommate who now resides in a different room than the room where the elopement took place. The roommate stated the curtain was closed between the 2 beds and he heard a banging noise and thought it was coming from the next room and he yelled out are you ok then he heard a loud shatter. He said Resident #2 broke the window and crawled out and was saying 'he wanted to go home' as he was leaving through the window. He stated after that he pushed his call bell to let the nurses know. An inquiry was made if anyone came running into his room after the loud shatter sound of glass breaking to which he stated he had to use his call bell to get someone to the room. He stated it took about 10 minutes for someone to come into the room and he told them the resident had left and they noticed the broken window, there was glass everywhere and you could see blood. He stated he did not know how he broke the window, further stating 'I guess he really wanted to leave'. The roommate stated he had to change rooms because of the glass, and they had to board up the window, so they put him in this room. On 08/12/20 at approximately 1:30 PM, a request was made to the DON and ADON (Assistant Director of Nursing) for the facility policy for Resident Supervision. The ADON stated he will look for the Resident Supervision policy. On 08/12/20 at 2:00 PM, an interview was conducted with the DON who did the investigation of the elopement of Resident #2. An inquiry was made what was Resident #2 wearing and what time was he located to which she stated she thinks he had a shirt and pants on but the police would not allow her to go see him. She stated Resident #2 was found by the police in the vacant lot next door sitting down by some bushes. She stated the police have big spotlights that is how they found him. She was not certain what time the police found Resident #2. An inquiry was made if there was a trail of blood to which the DON stated he sustained many cuts so it would be assumed he was bleeding. An inquiry was made about how much time had elapsed from the last time the aide observed Resident #2 in his room to which she stated it was about 20 minutes. She stated the aide gave him something to drink, he went to the bathroom and then she left to go over to the other side (from the 400's hallway to the 300's hallway) to assist someone. She stated the roommate heard a bang and then Resident #2 was not there and he noticed the broken window. She stated the roommate activated his call light and the aide responded she believed about 10 minutes later after she was finished assisting another aide. An inquiry was made about the average census and evening shift staffing ratios of the North wing to which the DON stated it is about 52 and there are 2 aides each on the 300 and 400 hallway and one aide floats between the 2 halls. The DON confirmed the evening shift can be a busy time with doing evening bedtime care and delivering snacks to residents. An inquiry was made if any staff member heard the window shattering to which the DON stated nobody heard the window shatter, it was the roommate. An inquiry was made if the roommate happened to be incapable of using a call bell due to for example severe dementia, how long would it have been before it would have been noticed that Resident #2 broke the window and eloped. The DON had no comment. The DON confirmed that prior to the facility becoming a dedicated COVID-19 facility, the facility was a locked dementia unit. She also confirmed that the majority of their current admissions remain residents with moderate to severe dementia however they are also admitting residents who are more cognitively intact. An inquiry was made to the DON if there is a dedicated staff member or someone who patrols the halls on evenings to ensure resident safety and needs are being met aside from the 5 aides and 2 nurses responsible for 2 hallways on the North wing that are separated by a nursing station with the 300's hall and 400's hall cordoned off by closed double fire doors, to which she stated it has always been 5 aides and 2 nurses assigned for the North wing. A further inquiry was made if no staff member heard a window shattering on the 400's hallway, where was everybody, to which the DON concurred if nurses and aides are at the nursing station with the doors closed to the 400's hallway, or working down the 300's hallway which is also behind closed doors, you may not hear alarms going off or windows breaking when it occurs. An inquiry was made to the DON if Resident #2 had an Elopement Risk Assessment completed after the initial admission assessment done on 07/14/20 at 4:50 AM, to which she stated on admission Resident #2 was assessed as not a risk for elopement. She stated Resident #2 normally walked around back and forth and had never tried to leave before, stating she does not know what set him off this time. An inquiry was made again if Resident #2 had been reassessed for elopement risk since admission on 07/14/20 at 4:50 AM, to which she stated the resident just walked around a lot but never tried to leave until this incident. A further inquiry was made to the DON what measures have been put in

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) place to prevent this incident from occurring again to which she stated they are doing window check rounds daily and have done elopement assessments on all current residents. An inquiry was made if there were any plans to revise the evening staffing ratio to which the DON stated there is no plan to change the staffing ratio, there has always been 5 aides and 2 nurses on the evening shift. On 08/12/20 at approximately 2:30 PM, a second request was made to the ADON for the facility policy for Resident Supervision. He stated he is looking for it. On 08/12/20 at approximately 3:30 PM, a third request was made to the ADON for the facility policy for Resident Supervision. He stated he is looking for it. On 08/12/20 at approximately 4:00 PM during the exit conference with the Administrator, DON, ADON and Activity Director, a request was made to have the Resident Supervision policy forwarded to this surveyor electronically if they were still unable to locate the policy. The ADON acknowledged this and stated he will email the policy when found. As of 08/14/20, a Resident Supervision policy was not provided electronically and no communication was received either electronically or by telephone from the facility regarding any policies.
F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure nutritional assessments and interventions were done in a timely manner, and facility failed to address weight loss in a timely manner for 3 of 3 sampled residents (Resident #1, Resident #2 and Resident #3) reviewed for nutrition. The findings included: Record review of the facility's policy titled Weight Protocol, dated 09/17/19, showed that weight changes noted will be evaluated by dietetic professional and documented accordingly. It further showed weights will be monitored on a regular basis. All residents are weighed weekly times 4 weeks following admission, and monthly thereafter. It further showed that weight changes are reviewed and communicated to interdisciplinary team. Record review of the facility's policy titled Nutrition Assessment, dated 09/17/19, stated that residents with high nutritional risk will be assessed in a timely manner. It further showed that a nutritional review will be completed quarterly thereafter, annually, with significant change and as determined by the Registered Dietitian. 1. Record review of Resident #1 showed that he was admitted to the facility on [DATE] and discharged on [DATE] with Hospice care. Resident #1 had [DIAGNOSES REDACTED]. Review of Resident #1's weight history showed the following: 10/07/19, 163 pounds; 11/06/19, 160.3 pounds; 12/02/19, 153.6 pounds; 01/02/20, 156.8 pounds; 02/03/20, 158.8 pounds; 03/14/20, 159.2 pounds; 04/02/20, 157.8 pounds; 05/11/20, 145 pounds; and on 05/20/20, he was 147.2 pounds. Closer review of the weights trend showed that on 03/14/20, his weight was 159.2 pounds and on 05/11/20, he was at 145.0 pounds. That is 14.2 pounds weight loss which is 8.1% (significant) in about 7 weeks. Review of the Registered Dietitian progress notes showed that Resident #1 had a follow up note on 09/24/19, which showed that Resident #1's weight is stable, and he continued to be on Regular texture diet with a house shake supplement once a day and nutrition juice supplement once a day. The next follow up nutrition note was not until 05/16/20, which was 8 months later. Progress notes dated 05/16/20 stated that Resident #1 was triggered for significant weight loss and due to sudden weight loss over the past 30/90 days. In this assessment, Resident #1's weight is noted as trending down over the last 180 days. The Clinical Dietitian reassessed his nutritional needs and recommended to provide an additional nutrition supplements 3 times a day. Review of physicians' orders showed an order for [REDACTED].#1 was identified with weight loss. Record review of Resident #1's care plan dated 03/17/20 showed that he is at risk for weight changes related to dementia and [MEDICAL CONDITION] and his last care plan that was updated under nutrition was done on 09/23/19. Further review showed that Resident #1 was also at risk for impaired visual functions. Record review of the Minimum Data Set (MDS), dated [DATE] under section B for vision, showed that he had adequate vision. In an interview conducted on 08/11/20 at 2:00 PM, with the facility's Registered Dietitian, she reported that she monitors all weight loss daily and any significant weight loss is reported to her or nursing. According to her, weights are taken upon admission, and then weekly for one-month until stable. It is monthly unless a resident has significant weight loss then they will take weekly weights until stable. She further stated that most of the COVID-19 positive residents have poor appetite with lost sense of smell and taste. They need constant monitoring and plenty of nutritional supplements to fight the COVID-19 nutritional symptoms. When asked as to why weekly weights were not taken when it was identified that Resident #1 had a significant weight loss, she did not know. The surveyor expressed concern as to why it took 5 days to address the significant weight loss and that the additional nutritional supplements were added only on 05/18/20. Record review of Resident #1's Initial/Annual evaluation dated 06/04/20 showed his weight upon admission was 161.7 pounds. His Ideal Body Weight was 166 pounds and he was at risk for alteration in nutritional status. When surveyor asked the Minimum Data Set Coordinator for a printout of the daily percentage intake that was documented by the Certified Nurse Assistants, she reported that it is not possible to view once the Resident was discharged . 2. Record review of Resident #2 showed that he was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the weight history showed the following: 03/14/20, 182.2 pounds; 03/31/20, 170 pounds; 04/02/20, 170 pounds; 04/20/20, 173.8 pounds; 05/11/20, 161.9 pounds; 05/19/20, 154.2 pounds; 06/08/20, 152.2 pounds; 06/22/20, 154.4 pounds; 06/29/20, 158 pounds; 07/07/20, 152.6 pounds; and on 07/20/20, 152.5 pounds. Closer review showed that on 03/14/20, Resident #2's weight was 182.2 pounds and on 03/31/20, the weight was down to 170.0 pounds, which is a significant weight loss of 8.1 percent. Review of the Registered Dietitian Initial assessment dated [DATE] which was 7 days after admission showed that Resident #2 is eating 50 percent of his meals. It further showed that Resident #2 is at risk for altered nutrition and hydration. In this note, the Clinical Dietitian suggested a nutritional supplement twice a day and a snack. Review of the Physician orders did not show an order for [REDACTED].#2 showed that the Clinical Dietitian did not address the weight loss from 03/20/20 to 03/21/20 until 04/24/20. Progress notes dated 04/24/20 showed that Resident #2 had a significant weight loss of 6.7 percent. In this note, the Clinical Dietitian recommended to provide 120 millimeters of nutritional supplements 4 times a day. She further stated that the monthly weight of 170 pounds reflect significant weight loss of 12.2 pounds which is a 6.7 percent weight loss. Resident #2's weight was also related to inadequate intake and dislike of mechanical altered diet. Further review of the weights showed that on 04/20/20, the weight was at 173.8 pounds and on 05/11/20, it was at 161.9 pounds. Weight loss was not addressed by the Clinical Dietitian until 05/20/20. A progress note dated 04/17/20 showed that the Clinical Dietitian was made aware that Resident #2 did not like the Puree texture diet but did not address the weight changes. In an interview conducted on 08/11/20 at 2:00 PM, with the facility's Registered Dietitian, she reported that she is only in this facility 2-3 times a week and is not able to monitor all weight loss daily. She further stated that she only started to work full time at this facility in March of this year. According to her, some of the residents lost weight because of the COVID-19 signs and symptoms. She acknowledged all findings. 3. Record review of Resident #3 showed he was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of weights showed the following: 02/03/20, 140.2 pounds; 03/14/20, 136.0 pounds; 04/02/20, 132.8 pounds; 04/07/20, 131.2 pounds; 04/20/20, 128.6 pounds; 05/11/20, 119.2 pounds; 05/19/20, 116.6 pounds; 06/25/20, 115.6 pounds; 06/30/20, 114.9 pounds; 07/07/20, 111.8 pounds; and on 08/04/20, she was 104.4 pounds. Closer review of the weights showed that Resident #3 was 140.2 pounds on 02/03/20 and 128.6 pounds on 04/20/20. Further review showed that on 05/19/20 Resident's #3 weight was 116.6 pounds; and on 08/04/20, the weight dropped to 104.4 pounds. Record review of the progress notes done by the Clinical Dietitian showed that on 04/26/20, which was 6 days later, she addressed the weight loss from 140.2 pounds to 128.6 pounds. She further recommended nutritional supplements 120 milliliters of 2.0, 3 times a day. In this note, she reported that the resident was admitted to hospice on 01/04/20. Physician's order showed that nutritional supplement 2.0 was increased to 4 times a day only on 07/16/20. Review of the weight records showed that on 08/04/20, the weight for Resident #3 was recorded at 104.4 pounds The Registered Dietician did not do a follow up progress note until 08/11/20. Record review of the care plan dated 04/21/20 showed that Resident #3 is with alteration in nutritional status as evidenced by potential for weight loss changes related to varying po (oral) intake. The goal is for Resident #3 not to experience weight loss change from current weight. It further showed that some of the interventions in place are to: review all weights and notify the physician and the responsible party of Significant weight change, and monitor for any muscle wasting and any weight loss of 3 pounds in a week or over 5 percent in 1 month. In an interview conducted on 08/11/20 at 2:00 PM, with the facility's Registered Dietitian, she reported that many of the residents in the facility that are positive COVID-19 lose their sense of taste and smell. They are already compromised with poor appetite and they need plenty of nutritional supplements in place. When asked by surveyor as to why the weight loss was not addressed in a timely manner she did not know. She further acknowledged all findings.
F 0814 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Dispose of garbage and refuse properly.** Based on observation and interview, the facility failed to dispose of refuse properly. The findings included: In an observation conducted on 08/12/20 at 11:45 AM, accompanied by the Kitchen Manager, the following was noted: The dumpster

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	105680	A. BUILDING _____ B. WING _____	**08/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NSPIRE HEALTHCARE LAUDERHILL	**2599 NW 55TH AVE LAUDERHILL, FL 33313**

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 0814 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 4) area outside the facility showed a large dumpster that was filled with overflowing clear garage bags, and all around it as well. The large dumpster had live insects all around it. Further observation showed additional smaller garbage bins on the side of the large dumpster that were also overfilled with clear garbage bags. Photographic evidence obtained. In an interview conducted on 08/12/20 at 11:50 AM with the kitchen Manager, she reported that the garbage gets picked up once daily and that they are late this morning. She further stated that since there is so much garbage that is for one time use items, because of COVID-19 residents, it gets filled faster. According to her, an order has been placed for larger garbage bins outside as well. She further acknowledged all findings.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to ensure infection control practices were followed to ensure prevention of transmission of the COVID-19 virus as evidenced by improper glove use and hand hygiene; improper use of PPE (personal protective equipment); improper disposal of potentially contaminated waste; and inadequate set up of a dedicated COVID-19 unit. The findings included: Review of the facility's policy titled Hand hygiene effective 09/19/18, no revision date, documents .to reduce the spread of germs in the healthcare setting .hand hygiene should be performed before and after patient care .after glove removal .continue friction for a minimum of 20 seconds .apply hand rub to palm of hand . Review of the facility's Lauderhill COVID 19 Process provided by the ADON (Assistant Director of Nurses) documents .staff will doff (remove) PPE (gowns, gloves, hair covers) prior to exiting HOT Zones and immediately sanitize hands .staff will remove and throw away surgical mask and sanitize hands . 1. On 08/12/20 at 11:37 AM, observation revealed the facility's administrator leaving the COVID 19- South wing (hot zone) with a surgical mask over an N-95 respirator mask and a face shield over the face. Observation revealed the administrator walking towards the main door, then returned to the cleaning table area and without performing hand hygiene removed his face shield and with bare hands proceeded to clean the face shield. Further observations revealed the administrator left the clean area through the main door, walked toward the front of the building, stood by his office and removed his surgical mask. The administrator was called back to the clean area and he was holding his surgical mask touching the outside of the mask which is considered contaminated. An interview was conducted with the administrator and he was asked to state the process regarding the use of the surgical mask. The administrator asked for recommendations, then stated that he is supposed to remove his surgical mask inside the south wing before coming out to the clean area. Observation revealed the administrator discarded the surgical mask into the yellow bin located in the clean area and without hand hygiene, he touched the keypad to enter the code for entry to the facility's main lobby area and walked to his office. 2. On 08/12/20 at 11:52 AM, observation revealed Staff B, a Certified Nursing Assistant, wearing a hair cover, a face shield, a gown and gloves. Staff B entered residents' room [ROOM NUMBER] and exited the room at 11:53 AM with her gloves still on. She applied alcohol-based hand sanitizer to her gloved hands and then entered another resident room, 204 wearing the same pair of gloves worn in another resident's room. On 08/12/20 at 12:01 PM, an interview was conducted with Staff B who stated that she usually takes her gloves off and does hand hygiene. She said she forgot to do hand hygiene. On 08/12/20 at 12:05 PM, Staff I, a restorative aide, approached the surveyor and stated that they are wearing gloves at all times, and were educated to remove gloves, do hand hygiene after each interaction with residents, and then don one pair of gloves again. 3. On 08/12/20 at 12:10 PM, an interview was conducted with Staff C, a Registered Nurse, who stated that they were educated to don two pair of gloves when interacting with a resident, remove one pair, perform gloves sanitation with hand sanitizer, come out of the room, then remove gloves and perform hand sanitation down the hall. 4. On 08/12/20 at 12:15 PM, an interview was conducted with Staff D, Certified Nursing Assistant, who stated that she has three pair of gloves on, this was confirmed by observation. She stated that because of the residents out in the hallway and touching everything, she has to protect herself. Staff D stated that if she touches a resident, she removes one pair of gloves, then does gloves sanitation with hand sanitizer and keeps the other two pair on. On 08/12/20 at 12:20 PM, an interview was conducted with Staff E, a Certified Nursing Assistant, who stated that she changes gloves between resident but uses two pair of gloves because the gloves break easily. Observation revealed Staff E with two gloves on her right hand. 5. On 08/12/20 at 12:25 PM, observation revealed Staff B entered the biohazard waste room, dropped a bag of clothes, removed her gloves, performed hand hygiene for 10 seconds, with wet hands reached above her head for a roll of paper towel (not on a paper-towel holder), cut a piece, dried her hands and again reached to the paper towel for another piece of paper. 6. On 08/12/20 at 12:50 PM, observation revealed the facility's Social Services Director (SSD) leaving the COVID-19 South wing (hot zone) to the clean area with a hair cover, a surgical mask and a face shield in place. Observation revealed the SSD with bare hands cleaning her face shield and then placed the face shield into her dedicated compartment (shoe holder type) located in the clean area. On 08/12/20 at 12:52 PM, an interview was conducted with the SSD and the SSD was asked about her N-95 respirator. Observation revealed the SSD pulled her N-95 from her scrub top pocket touching the outside of the N-95, which is considered contaminated. The SSD stated that she normally places her N-95 in the dedicated compartment for her to re-use later, but was out of breath and removed the N-95 before leaving the unit and placed it in her pocket. The SSD was apprised regarding contamination of her scrub attire once she placed her respirator in her pocket. She stated that she will get a new N-95respirator. On 08/12/20 at 2:10 PM, during an interview with the Director of Nurses (DON). She was apprised regarding the staff performing glove sanitation and infection control concerns. The DON stated that it is wrong and that they are not to do glove sanitation and added that the staff was educated to remove their gloves and perform hand hygiene. The DON was asked to submit the facility's glove use policy. The DON was asked regarding the reusable Personal Protective equipment stored in the clean area and stated that they were instructed by the department of health to place their extended use respirators and face shields into the dedicated shoe like compartment [MEDICATION NAME]. She pointed to the [MEDICATION NAME] in the clean area. The DON stated that they change the N-95 respirator mask every 5 days. At the end of the survey, the DON was asked again for the facility's gloves use policy. She was instructed to fax a copy to the surveyor. On 08/14/20 at 2:30 PM, the facility failed to provide a copy of their gloves use policy as requested on 08/12/20. 7. In an observation conducted on 08/11/20 at 1:27 PM, Staff O, Occupational Therapist, was observed walking in the South wing that is one of the positive COVID-19 wings. She approached a room that had a 'clean' sign on the door at the end of the corridor. She was observed walking into the room with the full personal protective gear and proceeded to Doff (remove) her gown inside the clean room. In an interview conducted on 08/12/20 at 10:20 AM, Staff F, Registered Nurse, and on 08/12/20 at 10:30 AM, Staff G, Certified Nurse Assistant, reported that in the hot zones, the residents' rooms and the hallways are considered dirty except for the rooms that are posted with a clean sign of the doors. She further stated that before entering the clean rooms, you need to remove your dirty personal protective gear and dispose of it outside the door. In an interview conducted on 08/12/20 at 10:50 AM, Staff O, with Occupational Therapist, reported that the south wing is considered dirty in the rooms and in the hallway and that the clean room in the end of the corridor is a green zone. According to Staff O, before you go into the clean room, you remove the dirty gown and dispose of it outside the room. When asked as to why she was observed going into the clean room and then removing her dirty gown inside the room, she reported that there was no garbage bin outside the room and she had to use the garbage bin inside the clean room. She further stated that there is usually a garbage bin outside the room, but she did not know what happened to it. 8. On 08/11/20 at 2:50 PM, during an observation of the North unit 400's outside exit door accompanied by Licensed Practical Nurse Staff 'A', the trash dumpster outside to the left of the exit door was overflowing with bags of trash, blue mattresses in addition to a blue isolation gown hanging over and outside of the dumpster. Eight blue gloves were observed on the ground in front of the dumpster. On 08/11/20 at 3:57 PM, observation revealed the trash dumpster overflowing with trash with gloves on the ground in front of the dumpster and a blue isolation gown hanging over and outside of the dumpster. Photographic evidence obtained. On 08/12/20 at 9:11 AM, the trash dumpster was observed now overflowing with an additional blue isolation gown placed on top of the heap of trash. Placed next to the additional blue isolation gown was a red biohazard trash bag sitting on top of the heap of trash. Photographic evidence obtained. On 08/12/20 at 9:30 AM, the Assistant Director of Nursing (ADON) was shown the photos of the dumpster observations on 08/11 and 08/12/20. The ADON shook his head and stated this is not acceptable and he will take care of it. On 08/12/20 at 9:50 AM, the ADON stated he has looked at the dumpster and the Administrator has taken pictures. He stated they reviewed the trash in the dumpster and found that it looks like transporters, after dropping off a new resident, are disposing of their PPE (personal protective equipment) into their dumpster. He stated in the red biohazard bag they found a white full body jump suit that ambulance

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 5) personnel use which they do not use in this facility. The ADON stated the Administrator is writing letters to transport companies to ensure that the drivers/staff do not throw their PPE in their dumpster. The ADON confirmed they are a COVID dedicated facility and if transporters are bringing residents into the facility, the PPE they are throwing into the facility dumpster is considered potentially contaminated. The ADON stated the potentially contaminated PPE should be placed in a biohazard trash bin and not the regular garbage.
F 0885 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	Based on interviews and record review, the facility failed to inform residents, their representatives, and families of those residing in the facility by 5 PM the next calendar day of any confirmed positive COVID-19 staff members. The findings included: Record review of the facility's policy titled COVID-19-pandemic Plan states that residents and resident representatives will be notified by 5 PM the next calendar day following a single confirmed infection of COVID-19 staff. In a phone interview conducted on 08/11/20 at 8:30 AM, with Resident's #4 spouse, she reported that the facility is not being transparent as to what is the status of any COVID-19 positive residents/staff. Review of the facility's line list report showed that 6 staff members tested positive for COVID-19 dated: 08/08/20, 08/10/20, 08/09/20, 07/27/20, 07/15/20, and 07/14/20. In an interview conducted on 08/11/20 at 12:11 PM, with the facility's Social Worker, she reported that she is always in contact with the resident's families and representatives. When asked if she discloses any positive COVID-19 staff members to families or representatives she said no, but maybe the Administrator or the Assistant Director of Nursing is doing it. In an interview conducted on 08/12/20 at 12:20 PM, with the facility's Administrator, he reported that he has no policy on how to inform residents or resident's representative of any positive COVID-19 staff members. He further stated that he was unaware that they needed to disclose any Positive COVID-19 staff members. In an interview conducted on 08/12/20 at 12:30 PM, with the Assistant Director of Nursing, he stated that they have not been telling residents or resident's representatives of any COVID-19 positive staff. He further stated that he did not know that they needed to inform residents or resident's representatives of any positive COVID-19 staff members. He further acknowledged all findings