STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106007	A. BUILDING _____ B. WING _____	**07/14/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FLORIDEAN NURSING AND REHABILITATION CENTER, THE	**47 NW 32ND PLACE MIAMI, FL 33125**

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 0604 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records review, observations and interviews, the facility failed to safeguard resident's rights to be free from physical restraints for two residents (Resident # 1 and Resident #2) investigated for the use of physical restraints, out of six total sampled residents during a complaint investigation survey. The facility failed to ensure assessment or justification for the use of the physical restraints that kept residents from getting out of bed. This facility practice has the potential to have an adverse effect for Resident #1 and Resident #2. There were 78 residents residing in the facility at the time of the survey. The Findings Included: Review of the facility's policies and procedures revealed a policy for Physical Restraints dated 11/30/2014 and revised on 8/22/2017; Residents have the right to considerate and respectful care at all times and under all circumstances, with recognition of their personal dignity and safety in the least restrictive manner. As needed, the interdisciplinary team will evaluate the resident for the potential need for physical restraint. The restraint must be the least restrictive means available. If the resident is identified by the interdisciplinary team and/or a discipline as requiring further intervention due to safety concerns, alternative methods will be attempted before restraint application will be considered. Monitoring and release of restraints will be done according to any state specific regulation . The procedures included but not limited: A restraint evaluation will be performed by nursing to assess physical, mental and other contributing factors which indicate the need for restraint/enabler. The nurse will obtain the Physicians order for the restraint. This order will include the medical reason for the restraint. Restraint use is documented in the resident care plan and in the nurse's notes . Review of the Admissions Record for Resident # 1 revealed, The resident was admitted to the facility on [DATE]. His [DIAGNOSES REDACTED]. Review of the resident's quarterly Minimum Data Set ((MDS) dated [DATE] revealed the resident's Brief Interview of Mental Status (BIMS) score was 6 out of 15 indicating cognitive impairment. Further review of the MDS indicated no behavior nor behavioral symptoms. His active [DIAGNOSES REDACTED]. Review of the Admissions Record for Resident # 2 revealed, The resident was admitted to the facility on [DATE] and readmitted on [DATE]. His [DIAGNOSES REDACTED]. Review of quarterly MDS dated [DATE] revealed the resident's BIMS score was 6 out of 15 indicating cognitive impairment. Further review of the MDS indicated no behavior nor behavioral symptoms. No physical restraints used. Observation of Resident #1's and Resident #2's room on 7/14/20 at 10:00 AM revealed, Resident #1 was asleep in his bed. Resident #1's bed was completely surrounded by furniture devices. To the right side of the resident, adjacent to his bed was a wheelchair that was a closed folded-up wheelchair and a green colored arm side chair, adjacent to the resident's left side of the bed was a night table that was turned with the front against the cabinet and another folded closed wheelchair. (see photo). Resident #2 was not in the room and was in the activity room. On 7/14/2020 at 10:34 AM, Staff A, Certified Nursing Assistant (CNA) reported he worked in the facility for about a year. He received trainings that included caring for residents with dementia. He cared for some residents that showed behaviors such as screaming and agitation. Resident #1 and Resident #2 showed such behaviors at times. During the interview, Staff A agreed to observe Resident #1 and Resident #2's room. On 7/14/2020 at 10:37 AM, during observation and Interview on with Staff A, Resident #1 was in bed surrounded by the above-mentioned furniture items that included, a chair and a wheelchair to his right, and a desk and a wheelchair to his left. Staff A stated that it was common practice to place furniture around Resident#1 because at times, he attempted to get out of bed. Resident #2 also had behaviors that included attempts to get out of bed and worse Staff A reported he usually found both residents like that (with furniture placed around their bed) in the mornings, when he started his shift. He added that this had to be done because it was for the residents' safety. Interview and record review with Staff B, a Licensed Practical Nurse (LPN), on 7/14/2020 at 1:55 PM revealed, she was familiar with Residents #1 and Resident #2. The residents' plan of care included half side rails, for mobility. The LPN explained there was no clinical indication, assessment, nor plan of care to justify the use of physical restraints on the residents. She explained that with the help of Staff A, she helped Resident #2 out of bed that morning. In the process, they accidentally blocked Resident #1's bed. She only noticed all the furniture that surrounded Resident #1 later that morning, when she administered his medications. When I saw that, I told the CNA that when he sees that he needs to remove them because that is a form of restraint . I explained that to the CNA, he told me he did not know. The aid offered no explanation or justification for furniture noted to the left side of the resident. On 7/14/20 at 4:10 PM during an interview and record review with both the Facility's Director Of Nursing (DON) and the Assistant Director Of Nursing (ADON) revealed, Resident #2 had a fall without injury in on 3/15/20 and Resident #1 last fall occurred on 5/7/20, also without injuries. The residents plan of care did not include the use of physical restraints. Upon discussion of the above-mentioned observations, both the DON and ADON agreed it was not appropriate practice to place furniture around the residents' bed; it was a form of physical restraint. None of the residents required the use of physical restraints.

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.