STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105610	A. BUILDING _____ B. WING _____	**09/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PALM GARDEN OF AVENTURA	**21251 E DIXIE HIGHWAY NORTH MIAMI BEACH, FL 33180**

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F 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Reasonably accommodate the needs and preferences of each resident.** Based on observation, interview and record review, the facility failed to ensure reasonable accommodations of residents' needs for 3 (Resident #22, #353 and #86) out of 6 sampled residents, as evidenced by call lights were not within reach for Resident #22, #353 and #86. This facility's deficient practice has the potential to affect any of the 106 residents residing in the facility at the time of the survey. The findings included: Observation on 09/14/2020 at 8:20 AM revealed Resident # 22 lying on his bed, eating breakfast. The call light was not seen near the resident. Resident # 22 was asked where is call light was, Resident #22 stated that he did not know where it was and tried to find the call light that was noted on the floor and not within reach. (Photographic evidence) Observation on 09/14/2020 at 8:25 AM revealed Resident #353 was lying in his bed; the call light was observed wrapped around and between the right bed rail and not within the resident's reach. (Photographic evidence) Observation on 09/14/2020 at 8: 35 AM revealed Resident # 86 in bed with eyes closed. The call light was observed on the floor and out of resident's reach. (Photographic evidence) On 09/16/20 at 8:40 AM Resident # 22 observed in bed finishing his breakfast. The call light was not within reach and was observed on the floor (Photographic evidence). On 09/16/20 08: 45 AM Resident # 353 was observed in bed and the call light was under a pillow that was located at to right at the head of the resident's bed and not within the resident's reach. (Photographic evidence) On 09/16/2020 at 08:48 AM revealed Resident # 86 in bed with eyes closed. The call light was hanging on the side rail close to the floor beyond the resident's reach.(Photographic evidence) On 09/16/20 at 12:45 PM during an interview Staff I Registered Nurse (RN) stated, the process when care is provided to the residents was to place the call light within the resident's reach. Staff I explained that rounds are completed every two hours to see if the residents were safe including check if call light was in place. On 09/16/2020 at 2:57 PM, Staff J Certified Nursing Assistant (CNA) for Resident # 22 explained the routine care provided to the resident that included placing call light within reach. The surveyor went with Staff J to Resident # 22's room and the call light was observed on the floor. Staff J acknowledged that the call light was not within Resident 22's reach. On 09/17/2020 at 12:57 PM, Staff K (CNA) revealed she was assigned to Resident # 86 and Resident #353 for the 7:00 AM to 3:00 PM shift. Staff K, CNA explained the routine care provided for each resident including making rounds every two hours. Staff K stated that the call light should always be within the resident's reach. On 09/17/2020 at 3:28 PM the Director of Nursing stated the facility created a team with the Head of each Department. The team passed by each resident's room, to help residents with the remote control, check if anything is broken and call ensure the lights were within reach. Review of the facility's policy titled Facility Call Light Policy and Procedures dated October 2014 indicates, the resident has to be comfortable as possible. Position the call light within easy reach of the resident.
F 0645 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**PASARR screening for Mental disorders or Intellectual Disabilities** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility failed to complete a Level II Pre-Admission Screening and Resident Review (Level II PASRR) for one (Resident#86) out of six residents reviewed for Level II PASRR. There were 106 residents residing in the facility at the time of the survey. The findings included: Review of clinical records for Resident # 86 revealed an initial admission date of [DATE]. Clinical [DIAGNOSES REDACTED]. Resident # 86's clinical records revealed a Level I PASRR indicating the resident was screened prior to admission to the facility on [DATE]. Section A of the document indicated Mental Illness was checked for [MEDICAL CONDITION]. Section II for other indications for PASRR Screen Decision Making revealed: 1-There is an indication the resident has a disorder resulting in functional limitations in major life activities. 3-B Due to the mental illness, the individual has experienced episodes of significant disruption to the normal living situation, requiring supportive services. Section III PASRR Screen Provisional Admission revealed the resident is not a provisional admission. Section IV PASRR Screen Completion revealed the resident should not be admitted to a Nursing Facility due to Serious Mental Illness. Review of the Social Services notes for Resident # 86 did not have a Level II PASRR. Review of the Initial Psychiatric Evaluation completed on 07/23/2020 indicated the reason for the Psychiatric Evaluation: The resident became aggressive stating that he wanted to leave. Resident becomes agitated when they trying to assist with daily care. Psychiatric recommended Psychotherapy 15 minutes with /resident. and Counseling and Coordination of Care. Review of physician's orders [REDACTED].# 86 Brief Interview for Mental Status (BIMS) is 99, meaning the resident could not answer any interview questions due to severe cognitive impairment. Section D for Mood revealed Resident # 86 did not answer any of the questions asked. Total severity Score is 02. Review of Nurse Notes dated 08/18/2020 revealed Resident # 86 had behavior problems related to agitation, anxiety, Dementia/Alzheimer's, rejecting care, behavior problems related to repeated failures to follow redirection and verbal symptoms toward others. Review of Social Services notes dated 08/24/2020 revealed Resident # 86 had periods of confusions and becomes restless, yelling and screaming at times, resists care and combative at times. On 09/16/20 at 1:08 PM, Staff H Social Worker Assistant stated, Resident # 86 was admitted with the Level I PASSAR screening that had been completed by the hospital personnel before the resident was admitted to the facility from the hospital. The PASRR was reviewed by the Social Services Director, Director of Nursing (DON), Nurse Unit Manager and the Admission Director. Staff H, Social Worker Assistant explained that when the Level I is negative, no Mental Disorder is identified, the resident is admitted to the facility. If the resident had mental illness, as showed in the LEVEL I, then the facility send it to KEPRO (Keystone Peer Review Organization) and then KEPRO would respond, if the resident is ok to be admitted . Staff H acknowledged the Level I PASRR that was in the resident's chart. Staff H stated that a PASRR Level I should be repeated or a Level II PASRR to see if the resident could have passed it in order to be admitted to the facility. Staff H stated that a Level II PASRR would be completed immediately in order for the resident to stay in the facility. On 09/17/2020 at 10:05 AM, the Administrator stated that the facility has no PASRR Policy and Procedures.
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, interview, and record review, the facility failed to implement care plans for: 1) one (resident #85) out of two sampled residents with skin conditions (non-pressure related) for an ongoing skin condition and change in skin integrity, and 2) one (resident #403) out of two sampled residents reviewed for respiratory care related to prescribed oxygen levels. There were a total of 106 residents in the facility at the time of this survey. The Findings included: 1). Record review of the medical face sheet for resident #85 revealed that the resident was admitted to the facility on [DATE]. Observation on 09/14/2020 at 12:10 PM revealed resident #85 in bed receiving oxygen treatment. The resident was alert, but was not interviewable. Further observation revealed that the resident had a skin tear to the bridge of her nose, and a scab

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.

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F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) to her chin. Record review of the nurses notes for the months of August 2020 and September 2020 revealed no documentation of any changes in resident #85's skin. Record review of the weekly skin checks for the months of August 2020 and September 2020 revealed no documentation of resident #85 having any issues with her skin, and that her skin was intact. Record review of the risk of alteration in skin integrity care plan dated 08/05/2020 revealed that resident #85 was care planned for the risk of alteration in skin integrity with a goal date of 11/04/2020. The interventions included, but not limited to, observing for signs and symptoms of alteration in skin and report. Interview with the Certified Nursing Assistant (Staff J) on 09/16/2020 at 2:58 PM revealed that she worked with resident #85 and that the scab on her chin was from a wart, and if it was not cleaned gently it would bleed; the resident had this a long time ago. However, Staff J was not sure about the resident's nose; and stated that maybe she scratched herself. Interview with the Wound Care Nurse and Licensed Practical Nurse (Staff I) on 09/16/2020 at 3:13 PM revealed that the Wound Care Nurse was not aware of any wart on resident #85's chin, or a scratch on her nose. The Wound Care Nurse went to assess the resident and returned at 3:17 PM and stated that it looked like resident #85 scratched her nose. It looked like a mole on her chin that she scratched, which was why there was a scab there. Staff I stated that the scratch on her nose looked fresh, and since resident #85 came into the facility she had something on her chin. She was going to inform the physician about it and clean it. The Wound Care nurse reported that she would then follow up. Both of the staff members were not aware about the resident's chin bleeding if it was not cleaned gently. 2). Record review of the medical face sheet for resident #403 revealed that the resident was admitted to the facility with a primary [DIAGNOSES REDACTED]. Review of the Physician order [REDACTED].#403 revealed that the resident was prescribed continuous oxygen (O2) at 2 liters per minute (LPM) via nasal cannula every shift. Review of the respiratory care plan dated 08/28/2020 revealed that resident #403 was care planned for the potential for altered respiratory status and difficulty breathing, related to acute [MEDICAL CONDITION], with a goal date of 12/09/2020. The interventions included, but not limited to, oxygen as ordered. Observation on 09/14/2020 at 10:17 AM, revealed resident #403 in bed sleeping while receiving oxygen. Further observation of the oxygen concentrator revealed that the resident was receiving O2 at 3 LPM. Observation on 09/15/2020 at 9:26 AM revealed resident #403 was in bed receiving oxygen at 2.5 LPM; the resident did not appear to be in any pain or distress, but was not interviewable. Observation and interview with the Licensed Practical Nurse (Staff F) on 09/16/2020 at 3:38 PM revealed resident #403 in bed receiving her oxygen via nasal cannula; the resident was not in any pain or distress. Further observation of the oxygen concentrator with Staff F present revealed that resident #403's oxygen level was at 3 LPM. Staff F stated that it was supposed to be at 2 liters, and that when she assessed the resident in the morning it was at 2 liters. She reported that because of how the oxygen concentrator was positioned the knob may have been touched and adjusted during the resident #403's morning care. Record review of the facility's policy and procedures titled, Comprehensive Care Plans, dated 11/2017, revealed that the document contained information on the development of care plans, but did not address the implementation of care plans.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide necessary services to maintain personal grooming for fingernail care, for residents assessed that required assistance to carry out activities of daily living(ADL). This facility's failure affected 5(Residents #22, #42, #54, #68, and #353) out of 7 residents assessed for ADL. There were 106 residents residing in the facility at the time of the survey. Findings included: 1) During observation of the evening meal on 09/16/20 Resident #22 was noted to have overgrown fingernails with debris under the nails. On 09/17/20 at 8:05 AM during an observation of breakfast Resident #22 was asked when the last time his fingernails had been cut, Resident #22 stated that he was not sure. Resident #22 stated that a girl use to come around and cut peoples nails, but she has not come around in months. At 8:08 AM the Director of Nursing was made aware Resident #22 would like his fingernails cut. Resident #22 was originally admitted to the facility on [DATE] with multiple hospitalization s and readmissions, the most recent readmission was on 07/14/20. Review of Resident #22's most recent Minimum Data Set (MDS) was an admission assessment of 07/14/20. Resident #22's Brief Interview for Mental Status (BIMS) revealed a score of 15 out of 15 indicating that Resident #22 is cognitively intact. Review of Resident #22's functional status revealed that the facility had assessed Resident #22 as needing extensive assistance with a physical assist of one person for all aspects of his personal hygiene. 2) On 09/17/20 at 8:11 AM Resident #42 was observed eating breakfast, his fingernails were overgrown and dirty. Resident #42 stated that he did not know how he was to go about getting his nails trimmed, but he would like them trimmed because they are too long. Staff B, a Certified Nursing Assistant (CNA) was at the bedside and stated that she would assist Resident #42. Staff B was asked if fingernail cutting is part of the care that the staff provided, Staff B stated yes. Resident #42 was originally admitted to the facility on [DATE]. Review of Resident #42's most recent MDS was a quarterly assessment of 07/10/20. Resident #42's BIMS revealed a score of 14 out of 15 indicating that Resident #42 is cognitively intact. Review of Resident #42's functional status revealed that the facility had assessed him as needing extensive assistance with a physical assist of one person for all aspects of his personal hygiene. 3) During an interview on 09/14/20 at 1:39 PM Resident #54 was observed to have overgrown fingernails with debris underneath. On 09/16/20 at 8:47 AM during an observation of catheter care Resident #54's fingernails were observed to be overgrown with debris underneath. On 09/17/20 at 7:40 AM Resident #54's fingernails were observed to be overgrown. Resident #54 stated that he was not sure the last time his nails had been cut. Resident #54 was originally admitted to the facility on [DATE]. Review of Resident #54's most recent MDS was a quarterly assessment of 07/03/20. Resident #54's BIMS revealed a score of 14 out of 15 indicating that Resident #54 is cognitively intact. Review of Resident #54's functional status revealed that the facility had assessed him as needing total assistance with a physical assist of one person for all aspects of his personal hygiene. 4) On 09/16/20 at 9:10 AM during a medication administration observation, Resident #68's fingernails were observed to be overgrown with debris underneath. On 09/17/20 at 8:21 AM Resident #68's fingernails were observed to be overgrown with debris under the nails. Resident #68 stated that a girl use to come around and do his nails, but she had stopped coming around several months ago. Staff F, a Licensed Practical Nurse (LPN) accompanied the surveyor to the room and observed Resident #68's fingernails. Staff F stated that the nails were long and needed to be trimmed and she would take care of it immediately. Staff F stated that nail care is a part of residents personal care. Resident #68 was originally admitted to the facility on [DATE]. Review of Resident #68's most recent MDS was a quarterly assessment of 06/19/20. Resident #68's BIMS revealed a score of 14 out of 15 indicating that Resident #68 is cognitively intact. Review of Resident #68's functional status revealed that the facility had assessed him as needing extensive assistance with a physical assist of one person for all aspects of his personal hygiene. 5) On 09/17/20 08:04 AM Resident #353 was observed consuming his breakfast. Resident #353's fingernails were observed to be overgrown with debris under the nails. Resident #353 was asked when his fingernails were last trimmed, the resident stated that he had no idea, he would like them cut but does not have any way of doing it. Staff G, a LPN and Unit Manager of the First Floor was standing outside Resident #353's room and made aware. Resident #353 was originally admitted to the facility on [DATE]. Review of Resident #353's most recent MDS was a quarterly assessment of 07/14/20. Resident #353's BIMS revealed a score of 9 out of 15 indicating that Resident #353 is moderately impaired cognitively. Review of Resident #353's functional status revealed that the facility had assessed him as needing extensive assistance with a physical assist of one person for all aspects of his personal hygiene. Review on 09/17/20 of the facility's policy and procedure for Nails, Care of Fingernails (Effective October 2014); Purpose: This procedure is to clean the nail bed, to keep nails trimmed, and to prevent infection. During an interview on 09/17/20 at 2:10 PM, the DON stated that fingernail care is part of the residents personal hygiene and staff should be assessing and maintaining residents fingernails.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to provide care and services for an ongoing skin condition and a change in skin integrity for one (resident #85) out of two sampled residents for skin conditions (non-pressure related). There were a total of 106 residents present in the facility at the time of this survey. The

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) Findings included: Record review of the medical face sheet for resident #85 revealed that the resident was admitted to the facility on [DATE]. Observation on 09/14/2020 at 12:10 PM revealed resident #85 in her room in bed receiving oxygen treatment. The resident was alert, but was not interviewable. Further observation revealed that the resident had a skin tear to the bridge of her nose, and a scab to her chin. Record review of the nurses notes for the months of August 2020 and September 2020 revealed no documentation of any changes in resident #85's skin. Record review of the weekly skin checks for the months of August 2020 and September 2020 revealed no documentation of resident #85 having any issues with her skin, and that her skin was intact. Interview with the Certified Nursing Assistant (Staff J) on 09/16/2020 at 2:58 PM revealed that she worked with resident #85 and that the scab on her chin was from a wart, and if it was not cleaned gently it would bleed; the resident had this a long time ago. However, Staff J was not sure about the resident's nose; maybe she scratched herself. Interview with the Wound Care Nurse and Licensed Practical Nurse (Staff I) on 09/16/2020 at 3:13 PM revealed that the Wound Care Nurse was not aware of any wart on resident #85's chin, or a scratch on her nose. The Wound Care Nurse went to assess the resident and reported at 3:17 PM that it looked like resident #85 scratched her nose. It looked like a mole on her chin that she scratched, which was why there was a scab there. Staff I stated that the scratch on her nose looked fresh, and since resident #85 came into the facility she had something on her chin. She was going to inform the physician about it and clean it. The Wound Care nurse reported that she would then follow up. Both of the staff members were not aware about the resident's chin bleeding if it was not cleaned gently. Record review of the facility's policy and procedures titled, Skin and Wound Care Team, dated 10/2014, revealed, A skin and wound care team is required to be in place as part of an ongoing Quality Assurance process. This team will be responsible for the management and monitoring of each resident's wound and skin concerns.
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, and record review, the facility failed to provide appropriate respiratory care and services for one (resident #403) out of two sampled residents reviewed for respiratory care. This had the potential to affect 6 residents that were receiving respiratory treatment in the facility at the time of this survey. The Findings included: Record review of the facility's policy and procedures titled, Oxygen Administration, dated 10/2014, revealed, The purpose of this procedure is to provide guidelines for oxygen administration.Turn on the oxygen. Start the flow of oxygen at the prescribed rate.Adjust the delivery device so that it is comfortable to the resident and the proper flow of oxygen is being administered. Record review of the medical face sheet for resident #403 revealed that the resident was admitted to the facility with a primary [DIAGNOSES REDACTED]. Record review of the physician order [REDACTED].#403 revealed that the resident was prescribed continuous oxygen (O2) at 2 liters per minute (LPM) via nasal cannula every shift. Observation on 09/14/2020 at 10:17 am revealed resident #403 in her room in bed sleeping while receiving oxygen. Further observation of the oxygen concentrator revealed that the resident was receiving O2 at 3 LPM. Observation on 09/15/2020 at 9:26 am revealed resident #403 was in bed receiving oxygen at 2.5 LPM; the resident did not appear to be in any pain or distress, but was not interviewable. Observation and interview with the Licensed Practical Nurse (Staff F) on 09/16/2020 at 3:38 pm revealed resident #403 in bed receiving her oxygen via nasal cannula; the resident was not in any pain or distress. Further observation of the oxygen concentrator with Staff F present revealed that resident #403's oxygen level was at 3 LPM. Staff F stated that it was supposed to be at 2 liters, and that when she assessed the resident this morning it was at 2 liters. She reported that because of how the oxygen concentrator was positioned the knob may have been touched and adjusted during the resident #403's morning care.