STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105709	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48906 Based on observations, record review and interview facility failed to accurately code a Minimum Data Set (MDS) for one resident (Resident #34) out of nine sampled residents, as evidenced by hearing aids not included in Section B of the Medicare 5-day MDS with reference date of 7/8/24 despite Resident #34 using hearing aids on a daily basis. The findings included: On 8/26/24 at 9:05 AM Resident #34 signaled to surveyor her inability to hear and to come closer. Hearing aids observed on nightstand. On 8/28/24 at 1:20 PM Resident #34 was seated in a wheelchair near bed. Hearing aids in place. Family at bedside. Record review of demographic sheet for Resident #34 revealed an admitted [DATE] with Diagnosis that included: Dementia. Record review of a Medicare 5-day Minimum Data Set (MDS) with reference date of 7/8/24 for Resident#34 Section B revealed Hearing- Adequate, Hearing Aid- No, Ability to Understand others: understands. Record review of a Care Plan initiated on 6/10/24 revealed Resident #34 had an Activities of Daily Living (ADL) self-care performance deficit related to hearing difficulty with a goal of will improve current level of function in ADLs through next review. The interventions included: Encourage resident to participate in fullest extent possible with each interaction. Record review of a physician's order sheet revealed an order dated 6/11/24 for diagnosis: Hearing Difficulty. On 8/29/24 at 9:15 AM The Social Services Director reported ; the Medicare 5-day MDS dated [DATE] Section B for Resident #34 is incorrectly coded and Section B should have be coded to included hearing aids. (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Policies and Procedures: Subject: MDS Effective Date: 11/30/2014 Revision Date: 9/25/2017 Policy: The center conducts initial and periodic standardized, comprehensive and reproducible assessments no less than every three months for each resident including, but not limited to, the collection of data regarding functional status, strengths, weaknesses, and preferences using the federal and/or state required RAI. Procedure: Specified sections of the RAI process are completed by the center designated Interdisciplinary Team Members. Each person completing a section or portion of a section of the MDS signs the Attestation Statement indicating its accuracy.

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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** 39177 Based on observations, record review and interview the facility failed to implement precautions to prevent catheter related injuries for two residents (Resident # 352 and Resident # 21) out of the three residents with indwelling catheters residing in the facility. As evidenced by Resident # 352 and Resident #21 indwelling catheter tubing were each observed touching the floor; and failed to ensure one out of one resident (Resident #252) with a prescribed order for skin tear treatment was implemented timely. Resident # 352 On 08/28/24 at 9:37 AM Resident #352 was observed seated in her wheelchair propelling along the hallway outside he room, the indwelling urinary catheter tubing was on touching the floor self-propelling wheelchair. (Photo evidence) Review of Resident #352's Admission Record indicated an admitted d 08/08/2024. Clinical Diagnoses include but not limited to: Acute kidney failure, Retention of urine, Hydronephrosis with urethral stricture not elsewhere classified. Review of Resident #352's admission orders indicated monitor indwelling catheters per shift; Leg strap anchor to indwelling catheter in place q (every) shift may change indwelling catheter monthly and as needed for blockage or leakage. Review of Resident # 352's Care Plan Initiated 8/9/2024 documented the resident has indwelling catheter with [catheter size] balloon, for urinary retention . the resident will remain free from catheter related trauma through review date. Leg strap to anchor indwelling catheter. Check tubing for kinks each shift. Review of the Initial Assessment Minimum Data Set (MDS) dated [DATE] revealed Resident #352 coded for indwelling catheter use. On 08/28/24 at 9: 42 AM Resident #352 stated; I am doing much better, they changed my [catheter brand] yesterday and I am going home tomorrow. The catheter bag was noted dated 08/2/24. On 08/29/24 at 10:15 AM Staff I Registered Nurse (RN) revealed the resident has an indwelling urinary catheter due to urinary retention. The resident will be discharged tomorrow to home, she was in the facility for therapy. Staff I, RN was shown the photograph with Resident # 352 seated in the wheelchair and the catheter tubing on the floor; Staff I acknowledged the concern and stated: That it is an infection control problem. It was changed yesterday. But I am going to change it During a follow up observation with staff I, in the resident's restroom the nurse acknowledged the date on the catheter was 08/27/24 not 08/28/24; Staff I, RN reported she made a mistake. 51356 Resident #21 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/26/24 at 09:01 AM Resident #21 was observed sitting in her wheelchair at the left side of her bed. The indwelling catheter tubing was observed on the floor.(Photo evidence) On 08/28/24 at 12:00 PM Resident #21 was observed sitting in her wheelchair on the right side of her bed eating lunch. The indwelling catheter tubing was observed on the floor. Record review of the resident's admission records revealed, Resident # 21 was initially admitted to the facility on [DATE] and readmitted on [DATE]. The resident's clinical diagnoses include but not limited to: Retention of urine, unspecified, Acute Kidney failure and Diabetes Mellitus. Review of the orders for August 2024 include order dated 8/11/24 - Cranberry Oral Tablet (Cranberry (Vaccinium macrocarpon)) Give 1 tablet by mouth one time a day for UTI (urinary tract infection), order dated 8/26/24 - May change indwelling catheter monthly and as needed for blockage or leakage as needed and every day shift starting on the 25th and ending on the 25th every month, order dated 8/23/24 - Enhanced barrier precautions due to [] indwelling catheter every shift, order dated 8/6/24 - Maintain [] catheter with [size] on balloon for Urinary Retention and change PRN (as needed) for obstruction, order dated 8/13/24 F/U follow up) with Urology (catheter (dx) diagnosis: urinary retention) Review of the Admission Minimum Data Set (MDS) Modification of admitted d 8/16/24, indicated in Section C for Cognitive Patterns, BIMS (Brief Interview of Mental Status) documented a score of 13 out 15 indicating the resident is gave an intact cognitive response. Section GG - Functional Abilities: Functional Limitation in Range of Motion: upper and lower extremities - No impairment. Mobility Devices: Wheelchair? - Yes; Self Care: Eating - supervision or touching assistance. H - Bladder and Bowel: Indwelling catheter? - Yes Review of the Resident # 21 Care Plans revealed an initiated date of 8/14/2024 and revision dated 8/26/2024 indicated- Focus: This resident has a Urinary Tract infection related to (r/t) abnormal urinalysis Culture and Sensitivity. Goals: The residents urinary tract infection will resolve without complications by the review date. Interventions: encourage adequate fluid intake, enhance barrier precaution r/t intravenous Antibiotics. Give antibiotic therapy as ordered. Monitor/document for side effects and effectiveness. Focus: This resident has Indwelling Catheter with [size] for Urinary Retention Goals: The resident will be/remain free from catheter-related trauma through review date. Intervention: Position catheter bag and tubing below the level of the bladder and away from entrance room door, enhance barrier precaution r/t catheter. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 8/28/24 at 12:36 PM Staff C, RN (Registered Nurse) revealed the catheter should not be touching the floor. She reported the resident transfers herself from bed to chair. I do rounds to check and to make sure the indwelling tubing is in the correct position. I also educate the resident about infection control. On 08/28/24 at 02:43 PM, Staff D, Certified Nursing Assistant stated: I assist the resident transferring from bed to chair and from chair to bed. This resident does not transfer alone. 45019 Resident #252 Review of Resident #252's wound care note dated 06/14/2024 documented skin tear left ankle, Primary dressing-Mupirocin ointment, Secondary dressing: dry protective dressing, Dressing frequency: daily Review of Resident #252's weekly skin assessment note documented 6/14/24-left ankle (outer)-skin tear, treatment in place. Review of Resident #252 Treatment Administration Record (TAR) revealed there was no documentation for treatment to the resident's left ankle skin tear starting 06/14/2, treatment for the resident's left ankle skin tear started 06/21/24. Review of the medical records for Resident #252 revealed the resident was admitted to the facility on [DATE]. Clinical diagnoses included but not limited to: Seizures, Dementia, Gastrostomy status and Altered mental status. Resident # was discharged on [DATE] to the hospital. Review of the Physician's Orders Sheet for May-June 2024 revealed Resident #252 had orders that included but not limited to: 6/21/24-Mupirocin external ointment 2% -apply to left ankle topically every day shift for wound care, clean left ankle with normal saline, pat dry, apply Mupirocin and cover with dry dressing daily. Record review of Resident #252 's Discharge Return anticipated Minimum Data Set (MDS) dated [DATE] revealed: Section C for Cognitive Patterns documented Brief Interview for Mental Status Score 2, on a 0-15 scale indicating the resident is cognitively impaired. Section GG for Functional Status documented the resident required maximal assistance for Activities of Daily living. Section M for Skin Conditions documented no pressure ulcers or deep tissue injuries. Review of Resident #252 Care Plans Reference Dates 4/25/24 and 6/21/24 documented: The resident has potential/actual impairment to skin integrity related to fragile skin. Focus-the resident will maintain or develop clean and intact skin by the next review date. Interventions-encourage good nutrition and hydration to promote healthy skin, keep skin clean and dry, use lotion on dry skin, skin treatment to left ankle as ordered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/29/24 at 12:47 PM the Director of Nursing (DON) stated the resident did not have a foot fungus, the skin tear to the left ankle was discovered on 06/20/24. On 06/20/24 treatment to the left ankle skin tear was started with Mupirocin ointment daily, Surveyor and the DON viewed the skin assessment sheet dated 06/14/24, the weekly skin assessment indicated the resident had a skin tear to the left ankle and treatment was in place, DON stated the treatment administration record does not have any orders for treatment for a skin tear starting on 6/14/24, treatment for the resident's skin tear started on 06/20/24. The DON acknowledged there was a wound care order prescribed by the resident's physician on 06/14/24 for treatment for the left ankle skin tear for the resident that was not implemented. Interview on 08/29/24 at 01:34 PM the Registered Nurse Wound Care (Staff B) stated: I have been doing wound care here at the facility for almost two (2) years, I started seeing this resident on 6/20/24 for treatment to the skin tear on her left ankle, prior to 06/20/24 the floor nurses treated the resident's skin. I am not aware if there was a prior order for treatment for the skin tear to the left ankle. The orders for treatment are prescribed by the resident's physician. Review of the facility policy and procedure titled Clinical Guideline Skin and Wound dated 04/01/2017 states: To provide a system for identifying skin at risk, implementing individual interventions including evaluation and monitoring as indicated to promote skin health, healing and decrease worsening of/prevention of pressure injury. Process: License nurse to complete skin evaluation weekly and prior to transfer/discharge and document in the medical record. License nurses to document the presence of skin impairment/new skin impairment when observed and weekly until resolved.