

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  105336	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/24/2024
NAME OF PROVIDER OR SUPPLIER  Palms Care Center and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 3370 NW 47th Terrace Lauderdale Lakes, FL 33319	

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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 01948</b></p> <p>Based on observation, interview, and record review, the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable homelike interior for 3 of 3 residential units (200, 300, and 400), the Skilled Therapy Department, the Main Dining Room, the Activity Room, and the Main Lobby.</p> <p>The findings included:</p> <p>During the tour conducted on 10/21-22/24, resident meal observations conducted on 10/21-23/24, routine resident observations conducted on 10/21-23/24, and the environment tours conducted on 10/23-24/24 accompanied with the Corporate Maintenance Director, the Maintenance Director, and the Director of Housekeeping, the following were noted:</p> <p>200 Resident Unit:</p> <p>room [ROOM NUMBER]: Room windows soiled, and window screens torn and in disrepair.</p> <p>room [ROOM NUMBER]: Room windows soiled, and window screens torn and in disrepair.</p> <p>300 Resident Unit:</p> <p>room [ROOM NUMBER]/#302/#304: main hallway outside of rooms and inside of rooms noted pervasive and offensive body odor and food / garbage odor. Interviews with staff who requested to not be identified at the time of the observation stated that the resident located within room [ROOM NUMBER] is refusing routine room cleaning, routine linen changes, and ADL (Activities of Daily Living) hygiene.</p> <p>room [ROOM NUMBER]: Room walls damaged and in disrepair.</p> <p>room [ROOM NUMBER]: Room floor soiled and stained, and bathroom water pressure too low.</p> <p>room [ROOM NUMBER]: Room walls damaged and in disrepair, and room widow heavily soiled.</p> <p>room [ROOM NUMBER]: Room floor heavily soiled and stained throughout, exterior of room furniture was peeling. Pervasive room urine odor, room windows heavily soiled, and privacy curtains (2) soiled and stained.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>room [ROOM NUMBER]: Bathroom toilet required re-caulking to the floor.</p> <p>room [ROOM NUMBER]: Old dialysis tubing required to be removed from the walls of the bathroom and main room. The large black tubing runs from the bathroom sinks onto the bathroom walls, through the bathroom walls and out into the mani bedroom walls all the way around to the beds. The black tubes are about waste high.</p> <p>room [ROOM NUMBER]: Bathroom shower chair seat cushion was torn, wood foot bed-frame heavily worn (D-bed), and call bell on floor (D-bed).</p> <p>room [ROOM NUMBER]: Old dialysis tubing required to be removed from the walls of the bathroom and main room. The large black tubing runs from the bathroom sinks onto the bathroom walls, through the bathroom walls and out into the mani bedroom walls all the way around to the beds. The black tubes are about waste high.</p> <p>room [ROOM NUMBER]: Soiled gloves (2) left on the bathroom floor.</p> <p>room [ROOM NUMBER]: Old dialysis tubing required to be removed from the walls of the bathroom and main room, and room windows soiled. The large black tubing runs from the bathroom sinks onto the bathroom walls, through the bathroom walls and out into the mani bedroom walls all the way around to the beds. The black tubes are about waste high.</p> <p>room [ROOM NUMBER]: Old dialysis tubing required to be removed from the walls of the bathroom and main room, and room windows heavily soiled. The large black tubing runs from the bathroom sinks onto the bathroom walls, through the bathroom walls and out into the mani bedroom walls all the way around to the beds. The black tubes are about waste high.</p> <p>room [ROOM NUMBER]: Room widows (2) soiled, and screens were torn.</p> <p>room [ROOM NUMBER]: Old dialysis tubing required to be removed from the walls of the bathroom and main room. The large black tubing runs from the bathroom sinks onto the bathroom walls, through the bathroom walls and out into the mani bedroom walls all the way around to the beds. The black tubes are about waste high.</p> <p>room [ROOM NUMBER]: Resident toothbrush left on bathroom floor.</p> <p>room [ROOM NUMBER]: Old dialysis tubing required to be removed from the walls of the bathroom and main room, and room widows (6) soiled, and screens were torn. The large black tubing runs from the bathroom sinks onto the bathroom walls, through the bathroom walls and out into the mani bedroom walls all the way around to the beds. The black tubes are about waste high.</p> <p>room [ROOM NUMBER]: Old dialysis tubing required to be removed [NAME] the walls of the bathroom and main room, bathroom mirror had desilverization, and room entry door exterior damaged and in disrepair. The large black tubing runs from the bathroom sinks onto the bathroom walls, through the bathroom walls and out into the mani bedroom walls all the way around to the beds. The black tubes are about waste high.</p> <p>Exit Corridor Doors: Do not shut tight and large space between doors noted.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Community Shower Room: Private bathroom / toilet area missing the privacy curtain.</p> <p>400 Resident Unit:</p> <p>room [ROOM NUMBER]: Exterior of room wall air-conditioner soiled and stained, and air conditioner filters (2) were heavily soiled and dust laden.</p> <p>room [ROOM NUMBER]: Room wall air cover was loose and falling off of the unit, and exterior of room entry door was in disrepair and damaged.</p> <p>room [ROOM NUMBER]: Room air-conditioning filters (2) were heavily soiled and dust laden.</p> <p>room [ROOM NUMBER]: Bathroom toilet tank lid off and not fitting, and Room air-conditioning filters (2) were heavily soiled and dust laden, and exterior of wall air-conditioning unit was stained and soiled.</p> <p>room [ROOM NUMBER]: Room air-conditioning filters (2) were heavily soiled and dust laden, and room walls damaged and in disrepair.</p> <p>room [ROOM NUMBER]: Room floor tiles (4) in disrepair, and old dialysis tubing requires to be removed to walls of the bathroom and main room.</p> <p>room [ROOM NUMBER]: Old dialysis tubing required to be removed from the walls of the bathroom and main room. The large black tubing runs from the bathroom sinks onto the bathroom walls, through the bathroom walls and out into the mani bedroom walls all the way around to the beds. The black tubes are about waste high.</p> <p>room [ROOM NUMBER]: Bathroom toilet required re-caulking to the floor.</p> <p>room [ROOM NUMBER]: Numerous large stains and scraped to room floor.</p> <p>Skilled Therapy Room:</p> <p>Parallel Bars: Bars (2) unstable, loose, and wobble. The floor area heavy soiled, worn, stained, and in need of replacement.</p> <p>Training Stairs: Stairs noted to be heavily soiled, stained, and non-slips taping in disrepair.</p> <p>Room Chairs - exterior cushions torn (2).</p> <p>Main Dining Room:</p> <p>Room windows (18) heavily covered in a green algae matter and residents unable to see outside of the room</p> <p>Room floor noted to have numerous and large black stains throughout the entire room.</p> <p>Numerous flying insects on all observations conducted on 10/21-23/24.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Room ceiling tiles (40) noted to be soiled, and brown stained throughout the room.</p> <p>Dining room tables (legs / spindles) noted to have areas of peeling black paint.</p> <p>Activity Room: Room walls (2) in need re-painting, and garbage containers (2) requires a lid covering.</p> <p>Main Lobby Area: Exterior of 3 of 3 sitting chairs heavily worn and in disrepair.</p> <p>Following the environment tours conducted on 10/23-24/24, the examples were again reviewed with the Corporate Maintenance Director, and were again discussed and confirmed with the Administrator.</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 01948</p> <p>Based on observation, interview, and record review, the facility failed to provide care and services for 2 of 2 sampled residents, Residents #23 and #97, who were to receive the restorative dining program; and failed to maintain the residents' ability to communicate and to participate in activities of daily living (ADLs) for 1 of 1 sampled resident, Resident #82,</p> <p>The findings included:</p> <p>1. Review of the clinical record of Resident #23 on 10/22-23/24 noted a readmitted [DATE] with current diagnoses of Alzheimer's Disease and Dementia. Review of the current physician orders included: On 12/04/23, Mechanical Soft Diet / Fortified Foods and Med Pass 2.0 - 120 ml Every Day, and Restorative Dining Program - Breakfast &amp; Lunch Meals 7 days per week.</p> <p>Review of the resident's weight history documented a current weight of 100 pounds, occurring weight loss, and a BMI (Body Mass Index) of 18.5, indicating the resident was underweight / malnourished.</p> <p>Review of the current care plan dated 10/01/24 documented: Nutritional Problem - consuming 25-50% of meals, requires assistance and supervision with meals. Review of the current interventions noted that a Restorative Dining Program with specific interventions were not documented.</p> <p>The ADL (Activities of Daily Living) functioning care plan noted documentation that the resident requires supervision with feeding and Restorative Dining one meal per day. No Restorative Dining Assessment could be located in the medical record of Resident #23.</p> <p>Review of the clinical record of Resident #97 on 10/23-24/24 noted an admitted [DATE] with current diagnoses to include Bipolar Disease, Dysphagia, and Alzheimer's Disease. The current physician orders noted: Plate Guard with meals (06/22/24), and No Added Salt / Mechanical Soft diet (04/16/24). No physician orders for Restorative Dining Program could be located in the medical record.</p> <p>Review of the current Minimum Data Set (MDS) assessment, dated 09/01/24, noted a Brief Interview for Mental Status (BIMS) score of 4, indicating severe cognition impairment; and assistance was required with eating. Review of weight history noted the weights were stable.</p> <p>Review of the current care plans revealed no Restorative Dining Program care plans could be located.</p> <p>During observation of the lunch meal in the Main Dining Room (MDR) on 10/21/24 at 12:30 PM, it was noted that Residents #23 and #97 were sitting at separate tables in the very rear of the dining room, away from other resident dining tables. Further observation revealed that the facility's Restorative Dining Program occurs in the rear of the Main Dining Room (MDR) and that Residents #23 and #97 were enrolled into that program.</p> <p>(continued on next page)</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Further observation of the lunch meal noted that Resident #23 had some cognitive impairment and would get up and walk away from the table 4 times during the meal. Each time the resident walked away, she was brought back to her table by staff in the dining room area and was told to eat her meal. At no time [NAME] the 45-minute lunch observation did any staff attempt to sit with Resident #23 and attempt to supervise or assist the resident with the meal intake. It was observed that Resident #23 consumed one 4-ounces of juice during the meal and approximately 5-10 % of the Mechanical Soft / Fortified Foods meal served.</p> <p>It was also observed during the same meal observation that Resident #97 had severe cognitive impairment and had position issues during the meal and would spill foods when attempting self-feeding onto his clothing protector and large amounts of pureed foods remained smeared on the resident's face throughout the meal. It was also noted that Resident #97 did not receive any individual restorative supervision and assistance throughout the 45-minute observation.</p> <p>Continued meal observations of Resident's #23 and #97 in the MDR on 10/22/24 (breakfast &amp; lunch), 10/23/24 (breakfast and lunch) and 10/24/24 (lunch) again noted the residents did not receive any restorative dining service that would include supervision and assistance for meals from the restorative nursing staff.</p> <p>On 10/22/24, an interview was conducted with the facility's Minimum Data Set (MDS) Coordinator concerning the facility's Restorative Dining Program. The surveyor requested a list of residents currently enrolled in the program and the restorative dining policies and procedures, that specifically addressed what restorative programs the facility has, who is in charge of the program, what staff are involved, how are residents are assessed to be enrolled into the programs, are physician orders required, what resident documentation is required on a regular basis, how are resident evaluated to remain on the programs, and evaluation of the restorative program on a regular basis.</p> <p>On 10/22/24, the MSD Cordinator submitted a list of the residents currently enrolled in the nursing restorative dining program. A review of the list noted that 2 of the residents listed were discharged from the facility months ago and the 2 other residents currently enrolled were Resident's #23 and #97. The coordinator also stated that there were no current up-to-date policies and procedures for the Nursing Restorative Dining Program.</p> <p>On 10/23/24, the administrator submitted a policy (1/2 page) for Restorative Nursing Services that did not address the requested policies and procedure for Restorative Nursing Services.</p> <p>During the observation of the lunch meal in the MDR on 10/24/24 at 12:30 PM, it was noted that due to surveyor intervention, both Residents #23 and #97 were receiving hands-on restorative dining interventions.</p> <p>50895</p> <p>2. Record review revealed Resident #82 was admitted to the facility on [DATE] with diagnoses that included hemiplegia and hemiparesis, Gastro-esophageal Reflux Disease, Muscle weakness, Muscle wasting and atrophy, Insomnia, Major Depressive Disorder, Anxiety Disorder, and Bipolar Disorder. Review of the Minimum Data Set quarterly assessment, dated 10/10/24, revealed Resident #82's Brief Interview for Mental Status (BIMS) score was 13, which indicated that she was cognitively intact.</p> <p>(continued on next page)</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview conducted on 10/21/24 at 11:00 AM, in the resident's language, revealed Resident #82 said that the language was a big barrier. When asked to explain further, Resident #82 said The ladies don't understand me, and I don't understand them. The resident was asked to provide an example of an incident when the language barrier presented a problem. She responded, if I want to request for my feet to be moved into a more comfortable position, or if I need my pillow to be adjusted, the nurses do not understand me.</p> <p>During a second interview, on 10/22/24 at 11:50 AM, the surveyor asked the resident if she participates in activities. Resident #82 said that she participated in the activities that she could understand, like watching TV in her room. When asked if there's an activity that she chose not to participate in because she could not understand English, Resident #82 answered, I can't see the movies because I don't understand them.</p> <p>Record review conducted on 10/24/24 at 9:15 AM revealed that Resident #82s care plan was last revised on 03/29/23. It was noted that no changes were made since its last review. The care plan stated: Resident #82 has a potential for alteration in communication r/t (related to): use of psychotropics, Speech is clear and easily understood and speaks mostly Spanish, patient [sig] uses a communication board. The Goal listed in the care plan said that the resident will continue to voice needs to staff without difficulty through the next review date. One intervention listed in this care plan documented that a Communication Board was provided to the resident along with education on how to use the Board. It also said Resident verbalize to therapist on understanding of the use of communication board. Keep call light within reach; respond to communicated needs.</p> <p>An interview with the Activities Director was conducted on 10/24/24 at 9:33 AM, who said that she knew Resident #82 and that she had worked in this facility for the past four months. When asked if this resident attended activities, the Activities Director responded, not necessarily and doesn't leave her room for activities very often. She added that Resident #82 preferred to stay in her room. The Activities Director said, She joined us 2 days ago in the activity room for coffee. She said Resident #82 preferred to be in her room and watch TV. When the Activities Director was asked if she spoke Spanish, she answered No. In response to how she communicated with Resident #82, the Activities Director said She's able to understand the basics. I ask her simple questions like are you ok and she says yes. The Activities Director informed the surveyor that there were no employees in the Activity Department who spoke Spanish, and she added that she printed out monthly calendars of activities written in Spanish for the seven or eight Spanish speaking residents. The surveyor inquired about showing movies in a group setting and the Activities Director said that showing movies was an activity that she provided to the residents. When asked if she might consider showing a movie in Spanish for her Spanish speaking residents, she answered Yes. That would be great.</p> <p>During an interview with Resident #82 at 10/24/24 at 9:55 AM, the Resident #82 said she wanted to speak more English and that she tries to speak English. She said she knew a few words in English. The surveyor said in Spanish that she would attempt to speak to her in English. The surveyor said, I spoke to the Director of Activities, and the resident shook her head. She did not understand. For that reason, the surveyor continued the interview in Spanish. The resident was asked if she had a communication board. Resident #82 pointed to a communication board posted on the wall next to the window. She said it was too far for her to reach it. She added that it would help her if it was within reach. Photographic Evidence Obtained, showing there was a communication board posted on the wall to the right of the window, that was out of reach for this resident.</p> <p>(continued on next page)</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview with the Director of Social Services on 10/25/24 at 11:33 AM revealed that she spoke a few words of Spanish, and that she called Spanish speaking employees when she needed assistance to communicate with Resident #82. She was unaware that Resident #82 had a communication board.</p>

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49060</p> <p>Based on observations, interviews, and record review, the facility failed to provide appropriate services to promote and maintain the highest practicable mental and psychosocial well-being for 1 of 1 sampled resident reviewed for Paranoid Schizophrenia (Resident #90).</p> <p>The findings included:</p> <p>Review of the facility's policy, titled, Behavioral Health Services, undated, included the following: Policy Interpretation and Implementation:</p> <p>2. Residents who exhibit signs of emotional / psychosocial distress receive services and support that address their individual needs and goals for care.</p> <p>Record review for Resident #90 revealed the resident was admitted to the facility on [DATE] and re-admission on 06/04/24 with the following diagnoses: Paranoid Personality Disorder, Delusional Disorders, Anxiety Disorder, and Paranoid Schizophrenia.</p> <p>Review of Section C of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #90 had a Brief Interview for Mental Status (BIMS) score of 15, indicating he was cognitively intact. Review of section GG of the same MDS revealed Resident #90 was independent for all Activities of Daily Living (ADLs), including toileting and the ability to bath himself (Does not include transferring in/out of tub/shower).</p> <p>Review of the Physician's Orders documented Resident #90 had an order dated 06/04/24 for Haldol Decanoate Intramuscular Solution 100 mg/ml, Inject 2 ml intramuscularly one time a day every 30 day(s) for Paranoid Schizophrenia.</p> <p>Review of the Care Plan dated 08/08/24 documented Resident #90 has the potential for adverse side effects related to the use of psychotropic medications: antipsychotic for treatment of Delusional Behavioral. The goal was for the resident to remain free from adverse side effects due to use of psychotropic medications thru the next review date. The interventions included: Administer psychotropic medications as ordered. Abnormal Involuntary Movement Scale (AIMS) assessment as indicated. Psychotropic review for dose reduction as able. Psychiatry Services or Psychological Services as ordered. Observe for changes in mood/behavior and report to physician if noted.</p> <p>(continued on next page)</p>		

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Care Plan dated 08/08/24 documented that Resident #90 has potential for self-care deficit with dressing, grooming, and bathing as evidenced by needs assistance with set up/supervision with personal care tasks. Resident #90 often refuses assistance with ADL care. The goal for the resident was: will continue to improve toward previous baseline ADL functioning throughout this review period and will allow staff to assist with ADLs as deemed necessary for proper hygiene and safety thru the next review date. The interventions included: Administer medications as ordered. Cue/encourage the resident to participate in ADL tasks. Allow resident ample time to attempt/complete ADL tasks before intervening. Encourage/remind the resident to ask for assistance as needed. Provide hands-on assistance with dressing, grooming, and bathing as needed. Explain actions during cares. Reapproach as needed.</p> <p>During an observation conducted on 10/21/24 at 10:30 AM of Resident #90's room revealed a strong body odor coming from the room which lingered into the hallway.</p> <p>During an interview conducted on 10/23/24 at 4:46 PM with Staff L, Certified Nursing Assistant (CNA), revealed she has been worked at the facility for 3 years and always assigned to the 3PM-11PM shifts in the north hallway (which included Resident #90's room). She stated Resident #90 sometimes requests towels and washclothes from her, but she has never observed the resident going to the shower room. Staff L noted the shower rooms are kept locked and only staff members have the code to unlock the door. She stated Resident #90 has never given her his personal clothing for laundry services. When asked who did his laundry, she stated she does not know, but the facility has not provided laundry services for Resident #90.</p> <p>An interview was conducted on 10/24/24 at 9:08 AM with the Administrator and Director of Nursing (DON). The Administrator stated Resident #90 has been refusing his medications, but has not shown any change in behaviors. In addition, she stated Resident #90 continues to refuse psychiatry visits, but he is reviewed for medications by psychiatry every month. She acknowledged Resident #90 often refuses showers and they do not receive his personal clothing for laundry services. When asked what the plan was to assist Resident #90 with his personal hygiene due to the foul body odor effecting the hallway and other residents, she stated, 'he likes to be left alone and they cannot force him to shower.'</p> <p>An interview was conducted on 10/24/24 at 11:29 AM with Staff J, Psychiatry Nurse Practitioner (Psych NP), who stated he has worked at the facility since November 2023. He stated he is concerned that Resident #90 continues to refuse his medications and is aware the resident has never taken the Haldol injectable as ordered. He agreed that another route of administration and other medications should have been tried. Staff J acknowledged he has not addressed the strong body odor. He stated the interdisciplinary team (IDT) has discussed Resident #90's hygiene practice, but to the management point, they do not see any solution to help with Resident #90's hygiene care because they can not force the resident to shower. He noted that this is something he would redirect to the psychologist therapist.</p> <p>An interview was conducted on 10/24/24 at 1:08 PM with Staff K, Psychologist Therapist, who stated, 'working at the facility Monday through Friday for 3 years'. He stated he has never had a conversation with Resident #90. Staff K acknowledged Resident #90's room has body odor and he tried to communicate with Resident #90.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Palms Care Center and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 3370 NW 47th Terrace Lauderdale Lakes, FL 33319	

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on 10/24/24 at 1:51 PM with Resident #75's relative (Resident #90's roommate). She was visiting her brother in his room and stated Resident #90 was verbally aggressive the first couple of times she came to visit her brother. She was aware of the strong body odor in the room, but she cleans her brother's area. She stated Resident #75 cannot communicate clearly and does not want to get anyone in trouble.</p> <p>On 10/24/24 at 2:17 PM an interview was conducted with Staff P, Registered Nurse (RN). She has been working at the facility for about 1 year. When asked about Resident #90, she stated he refuses medications, showers, and the resident can be intermediating scary. She is aware of the strong body odor; but she fears him and does not press the resident to take his medication or a shower.</p> <p>There ws no appropriate service to promote a plan or collective effort to provide hygiene care to Resident #90, as well as not providing laundry services and medication administration in attempt to promote and maintain the highest practicable mental and psychosocial well-being for Resident #90.</p>

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49060</p> <p>Based on observations, interviews, and record reviews, the facility failed to adequately monitor behaviors for residents receiving psychotropic medications for 3 of 6 sampled residents reviewed for psychotropic medications (Residents #90, #89, and #59).</p> <p>The findings included:</p> <p>Review of the facility's policy, titled, Behavioral Assessment, Intervention and Monitoring, revised March 2019, included the following:</p> <p>Policy Statement</p> <p>1.The facility will provide, and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care.</p> <p>6.The facility will comply with regulatory requirements related to the use of medications to manage behavioral changes.</p> <p>Management</p> <p>1.The interdisciplinary team (IDT) will evaluate behavioral symptoms in residents to determine the degree of severity, distress and potential safety risk to the resident, and develop a plan of care accordingly.</p> <p>Monitoring</p> <p>1.If the resident is being treated for altered behavior or mood, the IDT will seek and document any improvements or worsening in the individual's behavior, mood, and function.</p> <p>1. Record review for Resident #90 revealed the resident was admitted to the facility on [DATE] and re-admission on 06/04/24 with the diagnoses that included: Paranoid Personality Disorder, Delusional Disorders, Anxiety Disorder, and Paranoid Schizophrenia.</p> <p>Review of Section C of the Quarterly Minimum Data Set (MDS) assessment, dated 08/02/24, revealed Resident #90 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated that he was cognitively intact. Review of Section E of the same MDS revealed Resident #90 was not experiencing hallucinations or delusions; but was experiencing physical behavioral symptoms directed towards others (example: hitting, kicking, pushing, scratching, grabbing, abusing others sexually) and the frequency of these behavior occurred 4 to 6 days.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Palms Care Center and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 3370 NW 47th Terrace Lauderdale Lakes, FL 33319	
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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Physician's Orders showed that Resident #90 had an order dated 06/04/24 for Haldol Decanoate Intramuscular Solution 100 mg/ml, Inject 2 ml intramuscularly one time a day every 30 day(s) for Paranoid Schizophrenia.</p> <p>Review of the Physician's Orders showed that Resident #90 had an order dated 06/04/24 for Medication Management: Diagnosis (Dx) Paranoid Schizophrenia, 0 = no behavior, 1= Combativeness, 2= Verbally inappropriate, 3= Sexually inappropriate, 4= Disrobing, 5= Crying excessively, 6= Calling out constantly, 7= Screaming excessively, 8= Auditory Hallucinations, 9= Delusional, 10= Resists Care, 11= Socially inappropriate, 12= Extreme Pacing, 13= Restlessness, 14= Other, every shift for Monitor.</p> <p>Review of the Behavior Monitoring Record (BMR) for Resident #90 from 10/10/24 to 10/24/24 revealed only a check mark in some of the days for each shift (day and night). The documentation does not indicate a number (0 to 14) as ordered for behavior monitoring. There are nine days where a number was recorded but no interventions documented in the nursing notes on those days. There was no documentation on 10/12/24, 10/17/24, or 10/18/24.</p> <p>Review of the Behavior Monitoring and Interventions Task revealed no behaviors were observed from 10/10/24 to 10/24/24.</p> <p>Review of the Behavior Symptoms Task from 10/10/24 to 10/24/24 revealed no symptoms (14 symptoms listed) were observed during those days except on 10/15/24 but in which Resident #90 exhibit the following symptoms: Repeat movements, yelling/screaming, abusive language, and threatening behaviors.</p> <p>Review of the Care Plan dated 08/08/24 documented Resident #90 had exhibited the following behaviors: Hoarding food items, storing sharp objects, and refusing care; The resident yells and screams at staff when he is being educated or redirected. The goal was for the resident to exhibit a decrease in the number of behavior episodes by the next review date. The interventions included: Continue to monitor and assess resident surroundings as needed for compliance. Reinforce and educate resident on objects that are not permitted. Intervene as needed to protect the rights and safety of resident and others: remove from situation as able. Request psychiatric consult as needed.</p> <p>Review of the Florida Preadmission Screening and Resident Review (PASRR) Level II Determination Summary Report dated 06/11/24 included: given the history of Resident #90, care staff should monitor for depressive symptoms, symptoms of anxiety, or symptoms of psychosis, and report any problems to the treatment team.</p> <p>During an observation conducted on 10/21/24 at 10:30 AM of Resident #90's room revealed a strong body odor coming from the room which lingered to the hallway. The resident was in his room with the ceiling-suspended curtains pulled closed and he was speaking with someone, but no one else was in the room. The surveyor attempted to interview Resident #90, but he refused, and then his voice got louder and he continued with his conversation.</p> <p>An interview was conducted on 10/24/24 at 9:35 AM with the Director of Nursing (DON) who has been working at the facility for 3 years. When asked about what does the check marks mean in the BMR since the physician order is to record a number for behaviors, she stated she was not sure and would check the nursing progress notes for documentation. The DON acknowledged there was no documentation in the nursing progress notes.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Palms Care Center and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 3370 NW 47th Terrace Lauderdale Lakes, FL 33319	
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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on 10/24/24 at 11:29 AM with Staff J, Psychologist Nurse Practitioner (Psych NP) who stated he has worked at the facility since November 2023. He stated Resident #90 has not been aggressive towards him or other residents, but Resident #90 had an aggressive episode in June 2024 towards a staff member. Staff J acknowledged that he is concerned that Resident #90 has been refusing his medication and has been exhibiting abnormal thought processes: Paranoid delusions.</p> <p>An interview was conducted on 10/24/24 at 1:45 PM with Staff L, Certified Nursing Assistant (CNA), who stated she has worked at the facility for 3 years. When asked about Resident #90's behavior of aggression towards staff, she stated Resident #90 has never been aggressive towards her, but he has been aggressive towards other staff members. When asked if she would report Resident #90's aggressive behavior to the nurse, she stated not always because he does it all the time and this is his normal behavior.</p> <p>41837</p> <p>2 Record review for Resident #59 revealed the resident was admitted to the facility on [DATE] with the most recent readmission on 01/04/24. The resident's diagnoses included in part the following: Major Depressive Disorder.</p> <p>Review of the MDS for Resident #59 dated 07/19/24 documented in Section C a BIMS score of 15 indicating an intact cognitive response.</p> <p>Review of the Physician's Orders for Resident #59 revealed an order dated 01/04/24 for Duloxetine HCl Capsule Delayed Release Particles (a psychotropic medication) 60 MG give 1 capsule by mouth two times a day for Depression.</p> <p>Review of the Physician's Orders for Resident #59 revealed an order dated 01/04/24 Trazodone HCl Oral Tablet (a psychotropic medication) 100 MG give 1 tablet by mouth at bedtime for Depression.</p> <p>Review of the Physician's Orders for Resident #59 revealed an order dated 01/05/24 for Medication Management: Diagnosis Depression, 0 = no behavior 1 = Combativeness 2 = Verbally inappropriate 3 = Sexually inappropriate 4 = Disrobing 5 = Crying excessively 6 = Calling out constantly 7 = Screaming excessively 8 = Auditory Hallucinations 9 = Delusional 10 = Resists Care 11 = Socially inappropriate 12 = Extreme Pacing 13 = Restlessness 14 = Other, every shift.</p> <p>Review of the Medication Administration Record (MAR) for Resident #59 from 10/14/24 to 10/20/24 documented for medication management a check for each shift (day and night) but did not indicate if there were any behaviors or no behavior.</p> <p>Review of the nursing progress notes for Resident #59 from 10/14/24 to 10/22/24 revealed no documentation of behavior monitoring.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Palms Care Center and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  3370 NW 47th Terrace Lauderdale Lakes, FL 33319	
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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Care Plan for Resident #59 dated 10/25/23 with a focus on the resident has the potential for adverse side effects related to the use of psychotropic medications: antidepressant for treatment of Depression. The goals were for the resident to remain free from adverse side effects related to use of psychotropic medications and for the resident to receive the lowest effective dose of psychotropic medication to ensure maximum functional ability thru the next review date. The interventions included: Administer psychotropic medications as ordered. Observe for effectiveness of psychotropic medications. Observe for adverse side effects r/t psychotropic med use; report to physician if noted. Educate resident/family on potential risk/benefits of psychotropic medication use. AIMS assessment as indicated. Psychotropic review for dose reduction as able. Psychiatry Services or Psychological Services as ordered. Observe for changes in mood/behavior; report to physician if noted.</p> <p>3. Record review for Resident #89 revealed the resident was admitted to the facility on [DATE] with diagnoses that included in part the following: Unspecified Psychosis Not Due to a Substance Abuse or Known Physiological Condition, Major Depressive Disorder, Brief Psychotic Disorder, Other Specified Persistent Mood Disorders, and Generalized Anxiety Disorder.</p> <p>Review of the MDS for Resident #89 dated 07/19/24 revealed in Section C a BIMS score of 15 indicating an intact cognitive response.</p> <p>Review of the Physician's Orders for Resident #89 revealed an order dated 11/05/23 for Medication Management: Diagnosis Anxiety/insomnia 0 = no behavior 1 = Combativeness 2 = Verbally inappropriate 3 = Sexually inappropriate 4 = Disrobing 5= Crying excessively 6 = Calling out constantly 7 = Screaming excessively 8 = Auditory Hallucinations 9 = Delusional 10 = Resists Care 11= Socially inappropriate 12 = Extreme Pacing 13 = Restlessness 14 = Other, every shift.</p> <p>Review of the Physician's Orders for Resident #89 revealed an order dated 01/25/24 for Trazodone HCl Oral Tablet (a psychotropic medication) 50 MG give 1 tablet by mouth at bedtime for Depression.</p> <p>Review of the Physician's Orders for Resident #89 revealed an order dated 01/26/24 for Ambien CR Oral Tablet Extended Release (a psychotropic medication) 6.25 MG (Zolpidem Tartrate) give 1 tablet by mouth at bedtime for Insomnia.</p> <p>Review of the MAR for Resident #89 from 10/14/24 to 10/20/24 documented medication management documented each shift (day and night) with just a check mark, and no indication of a behavior observed or not behavior observed.</p> <p>Review of the nursing progress notes for Resident #89 from 10/14/24 to 10/20/24 revealed no documentation of behaviors or no behaviors noted for the resident.</p> <p>Review of the Care Plan for Resident #89 dated 08/08/23 with a focus on the resident has the potential for adverse side effects related to the use of psychotropic medications: antianxiety meds for anxiety and Hypnotics for insomnia, and antidepressant for depression. The goals were for the resident to remain free from adverse side effects r/t use of psychotropic medications and to receive the lowest effective dose of psychotropic medication to ensure maximum functional ability thru the next review date. The interventions included: Administer psychotropic medications as ordered. Observe for effectiveness of psychotropic medications. Observe for adverse side effects r/t psychotropic med use; report to physician if noted. Psychotropic review for dose reduction as able. Observe for changes in mood/behavior; report to physician if noted</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Palms Care Center and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 3370 NW 47th Terrace Lauderdale Lakes, FL 33319	
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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on 10/24/24 at 1:20 PM with Staff G, Licensed Practical Nurse (LPN), who stated she has been with the facility for [AGE] years. When asked about behavior monitoring for residents receiving psychotropic medication(s), she said they do monitor for behaviors. When asked where this is documented she said on the MAR.</p> <p>An interview was conducted on 10/24/24 at 1:20 PM with Staff H, LPN, who was asked about behavior monitoring for residents receiving psychotropic medications. She said they do monitor for behaviors. When asked where this is documented, she said on the MAR, and you put the code in for the specific behavior or a zero for no behavior.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>36057</p> <p>Based on observation, interview and review of policy and procedure, the facility failed to ensure that residents medications were properly stored as evidenced by medications being left on the resident's night stand for 1 of 1 sampled residents, Resident #26; and one opened bottle of Mucus Relief and one opened box of acetaminophen suppositories, over the counter medications (OTC), observed in the medication room cabinet for 1 of 2 medication storage rooms.</p> <p>The findings included:</p> <p>Review of the facility's policy, titled, Medication Labeling and Storage, revised 02/2023, provided by the Regional Nurse, documented, in part, The facility stores all medications .in locked compartments .the nursing staff is responsible for maintaining medications storage .in a clean, safe and sanitary manner medications are stored in an orderly manner in cabinets, drawers, carts each resident's medications are assigned to an individual cubicle, drawer, or other holding area .</p> <p>1. On 10/21/24 at 11:02 AM, during initial tour to the facility's south wing, an interview was conducted with Resident #26 who stated she had been in the facility for a few years. Observation revealed an opened over the counter (OTC) Antacid chewable bottle on top of the resident's nightstand. The resident stated she takes the antacid when she gets heartburn. The resident was asked if she told the nurse, stated she had not, and added that one nurse knows about it because the bottle was over on the windowsill and she moved it to the night stand. The resident could not remember the nurse's name.</p> <p>On 10/21/24 at 1:15 PM, observation during lunch time revealed Resident #26 in her room sitting at the edge of bed. Further observation revealed the opened bottle of an Antacid continued to be on top of the nightstand.</p> <p>On 10/23/24 at 10:29 AM, observation revealed Resident #26 in her room sitting at the edge of bed. Further observation revealed the opened bottle of an Antacid continued to be on top of the nightstand. Photographic Evidence Obtained.</p> <p>On 10/23/24 at 11:45 AM, an interview was conducted with Staff G, Licensed Practical Nurse (LPN) who stated she did not have any residents with the medications in their room and that residents were not supposed to. Staff G stated resident's OTC medications should be in the medication cart and had not noticed any medications in the residents' room. Staff G was asked to check Resident #26's night stand for OTC medication. Staff G stated she saw a bottle of Tums (antacid) on the resident's nightstand and added she gave the resident's medications this morning and did not notice it. Staff G was apprised the antacid bottle had been on top of the nightstand since Monday when the survey started. A side-by-side review of Resident #26's Tums (antacid) bottle, removed from the nightstand by Staff G, was conducted and revealed an expiration date on 11/2023. Staff G stated the resident did not have a physician order for Tums.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. On 10/22/24 at 1:21 PM, a side-by-side review of the facility's south wing medication room was conducted with Staff H, LPN and Staff N, LPN. The review revealed the following:</p> <ul style="list-style-type: none"> <li>-one opened bottle of Mucus Relief - Guaifenesin 400 mg opening date as of 07/12/24.</li> <li>-one box of 12 acetaminophen suppositories. The box had 10 of 12 suppositories left and did not have an opening date. During the review, Staff H, LPN stated once the medication bottle or a box was opened, it had to be dated and removed from the medication room to the medication cart. Staff H and Staff N confirmed the findings.</li> </ul> <p>On 10/22/24 at 2:05 PM, the surveyor was approached by the facility's Regional Nurse who stated the medication bottle in the medication room was an extra as it was an extra one in the medication cart; and had been moved to the medication room. The regional nurse was asked if an opened medication bottle was supposed to be in the medication room cabinet and replied No.</p> <p>On 10/24/24 at 2:55 PM, during an interview, the Administrator stated she was aware of the medication storage task findings.</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 01948</p> <p>Based on observation, interview, and record review, the facility failed to ensure that its Cycle menus (#1, #2, #3, and #4) met the nutritional requirements for daily milk / dairy servings and that the approved menu was being followed for potentially 105 of 113 facility's residents.</p> <p>The findings included:</p> <p>1. During the review of the current Cycle menu in use (Cycle #3) on 10/21/24, it was noted that only 8-ounces on milk / dairy was being served to residents on a daily basis. An interview conducted with the Corporate Dietary Manager (CDM) at the time of the review to review documentation of why the facility menus did not include the required 16-ounces of milk per day to the residents ([AGE] years or older). The surveyor specifically requested the government tool utilized to develop the facility's cycle menu.</p> <p>On 10/22/24, the CDM submitted to the surveyor a nutritional tool utilized for the development of the menus to be nutritionally adequate, and stated that an approved government tool was not utilized. Further interview and review noted an Optima Solutions Menu Template Nutrition Summary that was outsized for the menu development but the CDM explained to the surveyor that the facility menus did not included the required 2-8 ounces (16 ounce total) of milk per day.</p> <p>The CDM could not explain why the minimum milk requirement was not included on the facility's Cycle menus that included Cycles #1, #2, #3, and #4. The CDM additionally indicated that the menus would be revised on 10/22/24. It was noted that the issues with the milk servings potentially affected 105 of the facility's 113 residents.</p> <p>2. During the review of the approved Cycle #3's menu for the breakfast meal, it was noted that all residents were to be served an 8-ounce portion of milk which would include whole, 2 %, or fat-free.</p> <p>Observation of the breakfast meal in the main dining room of 10/22/24 at 8:30 AM noted that there were 18 resident's in attendance for the meal.</p> <p>Further observation noted that all of the the residents were receiving only 4-ounces of milk in a juice cup. The milk serving issue was brought to the attention of the Minimum Data Set (MDS) Coordinator who was present during the meal service in the main dining room. The coordinator stated that nursing staff were giving only 4-ounce cups for the milk serving and that a 8-ounce carton was utilized for 2 servings per 2 residents.</p> <p>Interview with the Food Service Manger during the meal revealed that the staff should have issued 8-10 ounce large beverage cups for residents' use to ensure that an 8-ounce portion of milk was being served according to the approved breakfast menu.</p>		

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NAME OF PROVIDER OR SUPPLIER  Palms Care Center and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 3370 NW 47th Terrace Lauderdale Lakes, FL 33319	
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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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p>50895</p> <p>Based on observation, interview, and record review, the facility failed to prepare food in a pureed form designed to meet the needs of 2 sampled residents of 14 residents with physician ordered pureed diets, Residents #4 and #110. The census at the time of survey was 113 residents.</p> <p>The findings included:</p> <p>Record review of the Nutrition Service Policy and Procedure effective 07/01/23, described the pureed diet as able to be piped, layered, molded if able to retain shape, but should not require chewing if presented in this form. The weekly menus that were labeled Spring / Summer Menus Week 3, from the Optima Solutions Dietary Management System, listed a description of the pureed diet on each menu. It said: Holds shape on spoon; smooth texture; No separated liquid; not firm/sticky.</p> <p>In the dining room on 10/21/24 at 1:04 PM, Resident #4's lunch plate was observed with beef stroganoff that was supposed to be pureed according to the diet listed on the meal ticket. The beef had small lumps in it.</p> <p>The surveyor then went into the kitchen and spoke to the Dietary Manager. Observation revealed that on the tray assembly line at 1:05 PM, a dietary aide placed a plate of pureed Beef Stroganoff on a tray for delivery to the unit. The plate with pureed Beef Stroganoff had a pebbly appearance. A spoonful of pureed Beef Stroganoff was requested and tasted. The texture had small lumps and strings. The Dietary Manager also tasted the pureed beef, and she agreed with this finding. The Dietary Manager removed the pureed Beef Stroganoff from the serving area and gave it to the cook, and asked the cook to puree it to a smooth texture.</p> <p>Photographic Evidence Obtained.</p> <p>In the Dining Room, at 1:25 PM, the pureed chicken on Resident #110's tray appeared to be lumpy. This was brought to the attention of the Dietary Manager in the kitchen. The Dietary Manager requested a taste of the pureed chicken and verified that the pureed chicken was not smooth. The surveyor also tasted the pureed chicken which was not smooth.</p> <p>Photographic Evidence Obtained.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50895</p> <p>Based on observations and interviews, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety, sanitary conditions, and the prevention of foodborne illnesses for 110 of 113 residents.</p> <p>The findings included:</p> <ol style="list-style-type: none"> <li>1. During the initial tour of the Main Kitchen on [DATE] at 9:30 AM, and accompanied by the Dietary Director, CDM (Certified Dietary Manager), the following was observed and noted:             <ol style="list-style-type: none"> <li>a. The walk-in refrigerator contained 2 expired items. The Marmalade was dated [DATE]. The Chicken Broth was dated [DATE].</li> <li>b. The dishwasher was a low temperature dishwasher. The rinse temperature reached 140' F. The sanitization of the dishware depended upon the adequacy of the sanitizing solution. The Dietary Director, CDM, was asked to perform a chlorine sanitizer test to determine if the sanitizing solution was adequate to sanitize the dishware. The first test strip was dipped into the dishwasher solution, and it did not change color. A second test strip trial was performed and again the test strip did not change color. This did not meet the requirement for the concentration of chlorine per the manufacturer's instructions which is ,d+[DATE] ppm. Photographic evidence was obtained.</li> <li>c. A chlorine sanitizer test was performed on bucket #2. It turned blue. This indicated that the concentration of the solution was 400 ppm. The sanitizing solution was too strong. The requirement for the concentration of chlorine per the manufacturer's instructions was between ,d+[DATE] ppm.</li> <li>d. The dietary storage room for emergency supplies had red and brown stains on the floor.</li> <li>e. The gray plastic trays used to store coffee cups had black scuff marks on the exterior corners and on the lower halves of the trays. This was pointed out to the Dietary Director, CDM. She acknowledged that the items looked worn out.</li> <li>f. The electrical outlets on the walls near the spice rack area were soiled with debris. The walls in the surrounding area had many small spots of exposed wall from peeled off paint.</li> <li>g. The bench mounted commercial can opener had worn off metal exterior with metal shavings present.</li> <li>h. The interior of both Vulcan ovens had thick black residue cooked onto the surfaces of the walls, the doors, and the floors of the ovens.</li> <li>i. The silver wall located to the right of the ovens was splattered with white residue markings that looked like drip marks splattered on a large area of the wall.</li> </ol> </li> </ol> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>j. The robocoup (small food processor) was stored with the top plastic cover closed tightly and a pool of water remained inside of the plastic container.</p> <p>k. The Arctic Air Commercial reach in freezer had 2 gaskets that showed areas of detachment from the door, where a wet, dark colored, slimy looking substance was observed located along the folds of the gasket.</p> <p>l. The Victory reach-in freezer's gaskets showed areas of detachment from the door where a wet, dark looking, slimy substance was observed located up and down along the gasket.</p> <p>m. The dry storage room floor in the back corner under the food racks had a white chalky looking substance on the floor and up the side of the adjacent wall.</p> <p>2. The Nourishment rooms were observed on [DATE] at 10:10 AM following the initial tour of the kitchen. The surveyors were accompanied by the Dietary Director, CDM (DD, CDM). The following was observed and noted:</p> <p>A. South wing nourishment room:</p> <p>a. The refrigerator in the South wing nourishment room had a bag of food with a use by date: [DATE].</p> <p>b. The interior of the microwave had food stains of various colors including red, purple, brown, and yellow.</p> <p>c. The gasket in the refrigerator was ripped and showed areas of detachment from the door.</p> <p>3. During a follow-up visit to the Main Kitchen on [DATE] at 08:15 AM, accompanied by the Dietary Director, CDM, the following was observed and noted:</p> <p>a. Surveyors observed food service employees placing breakfast foods onto plates and trays for delivery to the dining areas. There were plates and bowls that were stacked on a cart to be used on the breakfast trays. A small, white, plastic bowl had small black markings on it that looked like scuff marks. A plastic white plate was discolored with black marks, yellow splotches, and scratches on it. A plastic white compartment plate was stained with light black marks and 1 very dark black circular mark. These 3 items were given to the Dietary Manager, CDM, who removed them from the cart.</p> <p>Photographic Evidence Obtained of the above findings.</p> <p>The Dietary Director, CDM agreed with these findings.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50370</p> <p>Based on observations, interviews, facility policies, and record reviews, the facility failed to encourage hand hygiene, provide hand hygiene supplies, and assist residents in performing hand hygiene before meals for 6 of sampled 6 residents, Residents #14, #64, #30, #74, #95, and #27.</p> <p>The findings included:</p> <p>Review of policy, titled, SNF Clinic Handwashing/ Hand Hygiene - F880; Infection Control, submitted by the Administrator documented, in part, considers hand hygiene the primary means to prevent the spread of healthcare associated infection, and #6 explaining Residents are encouraged to practice hand hygiene.</p> <p>1. Record review revealed Resident #14 was admitted on [DATE] with diagnoses that included Protein-calorie malnutrition, Chronic Obstructive Pulmonary Disease (lung disease that blocks air flow causing difficulty of breathing), Muscle wasting and Atrophy (thinning of muscle).</p> <p>Record review of Minimum Data Set (MDS) assessment Section C dated 09/19/24, revealed a Brief Interview of Mental Status (BIMS) score of 15 indicating intact mental cognition. Section GG-A revealed Resident #14 needed eating set-up or clean-up assistance, and Section GG-I revealed set-up or clean-up assistance in washing and drying hands.</p> <p>An observation was conducted on 10/21/24 at 9:00 AM of an Enhanced Barrier Precautions (EBP) supply box and signage attached on Resident #14's door.</p> <p>In an interview with Resident #14 on 10/21/24 at 9:24 AM, when asked if Staff C provided wet towel with soap before a meal, she stated no. When asked if Staff C encouraged hand hygiene before eating a meal, Resident #14 stated no.</p> <p>An observation on 10/22/24 at 9:19 AM revealed Staff C, Admission Coordinator, delivered a breakfast tray to Resident #14. Staff C did not encourage hand hygiene and did not provide hand washing supplies to Resident #14. There was no packet of hand sanitizer observed inside Resident # 14's meal tray. There was no wet towel observed next to the meal tray.</p> <p>2. Record review revealed Resident #64 was admitted on [DATE] with diagnoses that included Hemiplegia and Hemiparesis (paralysis or weakness on one side of the body) and Cerebral infarction (a condition when the brain blood flow is blocked) affecting the left non-dominant side.</p> <p>Review of quarterly MDS section C dated 08/08/24 revealed a BIMS score of 13 indicating an intact cognitive function. MDS Section GG-A dated 08/20/24 revealed Resident #64 needed set-up or clean-up assistance in eating, while Section GG0115 revealed Resident #64 had one-sided functional impairment on both upper and lower extremities. A further MDS review of Section GG-I revealed Resident #64 required set up or clean-up assistance in washing and drying hands.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 10/22/24 at 9:22 AM, Resident #64 was hand manipulating a bed control, while Staff E, an Administrator-In-Training was setting up the breakfast tray on the table. While Staff E was centering the meal tray on the table, Resident #64 was picking up a juice container without first performing hand hygiene. Staff E did not encourage hand hygiene or provide hand hygiene assistance and supplies to the resident. The surveyor did not observe any packet of hand sanitizer or a wet towel next to the meal tray.</p> <p>In an interview with Resident #64 on 10/22/24 at 9:28 AM, when asked if Staff E encouraged hand hygiene or aided him in sanitizing his hands before eating, he stated no. When asked if Staff E had offered a wet soapy towel, followed by a dry towel before eating, he stated no. When asked if his meal tray has a packet of hand sanitizer, he said none.</p> <p>3. Record review revealed Resident #30 was admitted on [DATE] with diagnoses that included Hemiplegia and Hemiparesis following nontraumatic intracerebral hemorrhage (bleeding in or around the brain), affecting right non-dominant side, Essential Primary Hypertension, and Cerebrovascular Disease.</p> <p>Record review of annual MDS Section C dated 07/17/24 revealed a BIMS score of 15 indicating intact mental functioning. Section GG-A revealed Resident #30 required supervision or touching assistance during eating and Section GG-I dated 08/20/24 revealed Resident #30 needed set-up or clean-up assistance in washing and drying hands.</p> <p>During an observation on 10/22/24 at 9:06 AM, Resident # 30 was observed eating breakfast with one hand. He was putting a biscuit with gravy inside his mouth when the surveyor entered the resident's room. When asked if Staff encouraged hand washing before meals, he stated no. Upon closer observation, there was no packet of hand sanitizer inside the meal tray, or a wet towel observed on the table. When asked if staff provided him with a wet soapy towel and a dry towel before eating, he stated no.</p> <p>4. Record review revealed Resident #74 was admitted on [DATE] with diagnoses that included Benign neoplasm of the brain (non-cancerous mass growing in the brain), and blindness of both eyes.</p> <p>Review of annual MDS Section C dated 09/10/24 revealed a BIMS score of 15 indicating an intact cognitive function. Section B1000 revealed Resident #74's vision is severely impaired, and Section GG-A dated 09/20/24, revealed Resident #74 required set-up and clean-up assistance during eating.</p> <p>During an observation on 10/22/24 at 9:02 AM, Staff M, Medical Records Staff, uncovered the resident's breakfast plate. The resident immediately picked up a fork, then tried to peel a banana. Staff M did not encourage the resident to wash hands or perform hand hygiene. Resident # 74 was observed removing the crusts on her inner eyes and touching hre face before Staff M placed the meal tray on her bedside table. There was no packet of hand sanitizer on the meal tray or a wet towel on the table.</p> <p>In an interview with Resident #74, who was just waking up, on 10/22/24 at 9:05 AM, when asked if Staff M encouraged hand hygiene before breakfast, she stated no.</p> <p>5. Record review revealed Resident # 95 was admitted on [DATE] with the diagnoses that included Hemiplegia, and Hemiparesis after right cerebral infarction, and Osteoporosis with pathological fracture (broken bone caused by weakness).</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of MDS section C dated 10/10/24 revealed a BIMS score of 04 indicating severe impaired cognition. Section GG revealed Resident #95 had both functional impairments on one upper and one lower extremities. It revealed Resident needs set-up or clean-up assistance during eating, while MDS Section GG-I revealed Resident # 95 requires supervision or touching assistance in washing and drying hands.</p> <p>During an observation on 10/21/24 at 8:45 AM, an EBP (Enhanced Barrier Precautions) supply box and signage was observed attached on Resident 95's door.</p> <p>An observation on 10/22/24 at 9:50 AM, Staff F, Certified Nursing Assistant (CNA), went inside the resident's room. Staff F asked the resident if she wanted to eat breakfast. After the resident responded, Staff F left the resident's room and came back with sugar packets. Without performing hand sanitizing, Staff F added the sugar packets contents into Resident #95's oatmeal bowl.</p> <p>Staff F repositioned the resident for breakfast, and without sanitizing Resident #95's hands, allowed her to start eating. Staff F did not encourage the resident to perform hand hygiene before a meal and did not provide hand hygiene supplies to the resident.</p> <p>During interview with Staff F on 10/22/24 at 10:00 AM, she stated that facility staff sanitize hands before entering residents' room with EBP signage. She added the staff were educated to sanitize their hands before getting a meal tray from the meal cart and after delivering the meal tray to the residents' room. When asked if staff encourage the residents to perform hand hygiene before meals, she stated yes. When asked how staff provide hand hygiene to the residents who need mobility assistance, she stated Staff provide residents with towels wet with soap and water then assist the residents in sanitizing hands.</p> <p>6. Record review revealed Resident #27 was admitted on [DATE] with diagnoses that included Spinal Stenosis of the cervical region (bone disease when neck narrows and puts pressure on the spinal cord and nerves), Chronic Obstructive Pulmonary Disease, Obstructive and Reflux Uropathy (a urinary tract condition that causes urine to flow backwards), and Pyuria (urine containing white blood cells or pus).</p> <p>Review of the quarterly MDS Section C dated 10/02/24 revealed a BIMS score of 15 indicating an intact cognitive response. Section GG0115 of MDS revealed Resident # 27 had impairments on both upper and lower extremities, while Section GG0130A revealed the resident needed supervision or touching assistance during eating. Section GG-I revealed Resident #27 required substantial / maximal assistance in washing and drying hands. Section H dated 10/11/24 revealed a presence of suprapubic catheter, and Section M revealed a presence of Stage 1 pressure ulcer.</p> <p>During observation on 10/21/24 at 8:45 AM, Resident #27's door was observed with an EBP supply box and signage.</p> <p>Observation on 10/22/24 at 9:02 AM revealed Staff B, [NAME] clerk, placed the breakfast tray on the resident's bedside table. Staff B did not encourage Resident #27 to wash or sanitize hands before eating, and did not provide hand hygiene supplies to the resident.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>When Resident # 27 was asked if Staff B encouraged her to perform hand hygiene before a meal, she stated no. When asked if Staff B offered her cleaning supplies for her hands, she stated no. There was no wet towel next to the meal tray or a packet of hand sanitizer on the meal tray.</p> <p>In an interview with Staff A, Wound Care Nurse, Licensed Practical Nurse / LPN, on 10/23/24 at 9:30 AM, when asked how staff provides hand hygiene to the residents who required moving and standing assistance, she stated the staff educate residents regarding hand washing before and after meals and activities. Staff A stressed that Staff provide residents who need assistance in getting up, wet towels with soap and water before and after meals. She concluded that staff were educated to encourage and assist residents in hand hygiene, and/or provide hand washing and cleaning supplies to the residents before and after meals.</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 01948</p> <p>Based on observation, interview, and record review, the facility failed to maintain an effective pest control program so that the facility is free of pest (flies and roaches).</p> <p>The findings included:</p> <ol style="list-style-type: none"> <li>During resident screenings and routine observations conducted on 10/21/24 through 10/24/24, numerous sightings of flying insects were noted by the surveyors that included the following: <ol style="list-style-type: none"> <li>On 10/21/24 - Main Kitchen (7, 9 AM), 300 and 400 Units, and Main Dining Room (12:30 PM). Staff stated that flies and roaches are a common daily occurrence.</li> <li>On 10/22/24 - Main Dining Room (8 AM) and in resident Hallways (8 AM - 10 AM). Staff and residents stated that flies are a common daily occurrence.</li> <li>On 10/23/24 - Main kitchen (7 AM) and the resident Hallways (300 and 400 Unit). Staff stated that flies are a daily common occurrence.</li> <li>On 10/24//24 - Main Dining room [ROOM NUMBER] AM and 12 PM, the resident Common Areas, and the resident Hallways (200, 300, and 400 Units).</li> </ol> </li> </ol> <p>Photographic Evidence Obtained of above.</p> <ol style="list-style-type: none"> <li>During the review of facility's Pest Sighting Logs for August 2024, September 2024, and October 2024 (10/02-22/24), numerous sightings were documented by staff that included the following: <p>August 2024: Twenty-six documented sightings that included resident rooms and bathrooms and nourishment rooms. The areas were reported to the pest control company and documented as treated.</p> <p>September 2024 - Twenty-two documented sightings in resident rooms and bathrooms, staff offices, and nurses stations. The areas were reported to the pest control company and were documented as treated.</p> <p>October 2024 (10/01-22/24): Twenty-four documented sightings in resident rooms and bathrooms, nursing food pantry's, staff offices, and nurses stations. The areas were reported to the pest control company and were documented as treated.</p> </li> <li>During the review of the facility's pest control documentation for the months of August 2024, September 2024, and October 2024, it was noted the facility is having Bottle / Flesh Fly activity, standing inside water, accumulation of food products, tree / vegetation touching the building, and door gap/damage.</li> </ol> <p>Refer to F584 for additional findings.</p> <p>(continued on next page)</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. During an interview conducted by the surveyor with the facility pest control technician on 11/24/24 at 11 AM, it was confirmed that the facility has re-occurring monthly issues with flies and roaches. The pest control technician stated that the facility requires twice monthly treatments and as-needed treatments called in by the facility.</p>		