STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105508	A. Building B. Wing	01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
East Ridge Retirement Village Inc	19225 SW 87th Ave Cutler Bay, FL 33157

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - 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** 45019 Based on record review and interviews, the facility failed to ensure one (Resident #2) out of three sampled residents received care and treatment in accordance with professional standards of practice related to the timely reporting of a fall to the resident's physician resulting in a delay in care for a fracture. X-rays at the hospital revealed Resident # 2 incurred an acute fracture involving the right superior and inferior pubic rami. There were 69 residents residing in the facility at the time of the survey. The findings included: Review of the facility's policy and procedures titled, Provision of Quality Care date issued: 4/18/2023 states: Based on comprehensive assessments, the facility will ensure that residents receive treatment and care by qualified persons in accordance with professional standards of practice, the comprehensive person-centered care plans, and the residents' choices. Policy Explanation and Compliance Guidelines: 1. Each resident will be provided with care and services to attain or maintain his/her highest practical physical, mental, and psychosocial well-being. 2. A comprehensive care plan will be developed for each resident in accordance with procedures for development of the care plan. 3. Responsibility for interventions on the care plan will be clearly identified. 4. Qualified persons will provide the care and treatment in accordance with professional standards of practice, the residents' care plan, and the residents' choices. 5. To ensure persons are qualified, department heads, in collaboration with facility leadership and the HR department, will be responsible for verifying credentials of all employees prior to hire, and oversight to ensure ongoing employee competency, and education regarding areas of employee weaknesses. 6. Policies and procedures will reflect current professional standards of practice. All employees are responsible for following established policies and procedures. (continued on next page)

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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F 0684 Level of Harm - Actual harm Residents Affected - Few	b. Violations of policies and procedures will result in disciplinary action up to and including termination. During observation on 01/06/25 at 9:50 AM, Resident #2 was in bed awake, bilateral floor mats were present, the bed was in its lowest position, the call light was on the bed, there was no distress noted from the resident. On 01/07/25 at 8:10AM, resident #2 was in the wheel chair in the residents room receiving care, there was no distress noted. On 01/08/25 at 7:53AM, resident #2 was sitting at the side of bed receiving care from the Certified Nursing Assistant (CNA) (Staff D), the resident had nonskid socks and shoes on feet. The bilateral floor mats were present, no distress noted. Review of the medical records for Resident #2 revealed, the resident was admitted to the facility on [DATE]. Clinical diagnoses included but were not limited to: Superior rim of Right Pubis Fracture, History of Venous Thrombosis and Embolism, Contusion of other Urinary and Pelvic Organs, Generalized muscle Weakness, Other Abnormalities of Gait and Mobility, Pain. Resident #2 was discharged to the hospital on 12/21/24 and readmitted on [DATE]. Review of the Physician's Orders Sheet for January 2025 revealed, Resident #2 had orders that included but were not limited to: May use protective devices as needed such as floor mats, May use protective devices as needed heel floaters, Falls Risk Assessment (Quarterly), Bilateral floor mattress apply while resident in bed every shift. Medications included: Tramadol 50 mg tablet, 1 tab By Mouth Every 6 Hours as needed for Pain. Record review of Resident # 2's Annual Minimum Data Set (MDS) dated [DATE] revealed, Section C for Cognitive Patterns documented Brief Interview for Mental Status Score is 6 on a 0-15 scale indicating the resident is cognitively impaired. Section GG for Functional status documented the resident is dependent for care and requires assistance with mobility. Section H for Bowel and Bladder documented the resident has a ostomy and is always incontinent of bladder. Section J for Health Conditions documented no falls since readmission, no pain medications received in the last 5 days. Section N for Medications documented resident is receiving antianxiety, antidepressant, anticoagulant, and Hypoglycemic medications. Section O for Special Treatments documented no special treatments received. Section P for Restraints documented no alarms or restraints used. Record review of Resident #2 's Care Plans Reference Date 12/25/24 revealed: Resident have a potential for complications related to fractured status post fall with left hip fracture. Closed fracture of left superior and inferior pubic ramus and femoral. History of Right Femur fracture, Status post Fall sustained pubic ramus fracture. Resident will remain free of complications such as infection related to fracture through next review Interventions-Please provide me with patient teaching regarding my fracture and prevention of further incidents, Please keep my physician informed of any changes in my condition, Please monitor for edema to my affected extremity, Please monitor my vital signs. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Resident has a potential to fall related to: Impaired mobility, Impaired balance and gait. History of falls; Psychotropic drug use, status post fall sustained superior and anterior pubic ramus fracture. 09/25/23 Resident had an actual fall. Resident was observed ambulating without assistance and fell . 11/10/23 Resident was found on the floor in the bathroom. 03/01/24 Resident was found on the floor in the room. 06/19/24 Resident was found on the floor in the room. 12/06/24 Resident was heard yelling out from the room, found next to the bed, sitting straight up on her bottom. 12/20/24 Resident was observed on floor near the bed, laying on her right side. Resident would like to remain free from injury through date of next review. Interventions: May use floor mats next to bed per orders. Bilateral floor mattress apply while resident is in bed. Please be sure that my personal belongings are within my reach. Please take me to the toilet before and after my meals as well as before and after my activities. Please remind me to lock my wheelchair brakes and to ring for assistance when I need to transfer. Fall precautions: Keep my room clutter free and well lit. My call light within reach. My bed in low locked position. Review of the nursing progress notes for Resident #2 documented, 12/20/24 at 19:17(7:17pm), the resident was medicated with Tylenol 500mg X 2 tabs at approximately 9:30 am for (L) knee pain with a pain level of 6/10. Reevaluated one hour later the resident denied pain. The oncoming nurse to continue to monitor pain to (L) knee as the resident was observed holding the knee at times during the shift. 12/20/24 at 23:35(11:35pm), 911 dispatched to facility, family at bedside with resident, per family request refused transportation to hospital, under monitor and rounding, awaiting STAT Xray from [ ]Care. 12/21/24 at 6:48 AM, Results of Xray to skull, Right knee, Pelvis/hip revealed - demonstrate no acute fracture, results sent to resident's Physician (MD). Resident continue to yell for pain to right side during movement, propel with pillows and kept comfortable. Daughter at bedside, pain management in place. Colostomy in place and active, stoma is pink and moist, cleaned and kept dry. Bed in lowest position with call bell placed within reach. Safety measures maintained. 12/21/24 at 1:33PM, Stat Xray of Right knee, Skull and Pelvis done in facility as per order, resident yelling in pain when x-ray was being done, went to sleep immediately after x-ray was completed. Daughter at bedside. Bed in lowest position with call bell place within reach. Safety measures maintained. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	12/21/24 at 17:44(5:44pm) Resident received in bed with her daughter in recliner at the bedside. Vitals within Normal Limits, Temperature 97.6, respirations unlabored. Daughter stated the resident has pain on movement to her leg. All routine meds provided and tolerated. Resident was medicated with Tylenol 500 mg X 2 for pain, blood sugar monitored, and coverage given as needed. Daughter assisted with breakfast, resident ate approximately 50 %. Instructions received from physician to send the resident to the hospital report from [ ]Care stated the resident's right superior and inferior pubic rami are not diagnostically visualized and not cleared for an acute finding .further evaluation by Computed Tomography (CT) Scan is needed. Daughter/ granddaughter requested the resident be sent to the hospital. All necessary documents were prepared, and a call was placed to the ambulance service. Resident left the facility at approximately 10:30 am with the ambulance service. Resident's daughter was informed of time of transfer to hospital. The Nursing Supervisor also informed of the time of transfer to the. The resident's daughter called at approximately 3:45 pm to inform the nurse the resident will be kept overnight as there's a hematoma to the thigh and Labs will be done, if there's internal bleeding the resident will remain in the hospital, Registered Nurse appreciated the call. Review of x-rays completed at the facility on 12/21/14 at 1:45 AM revealed: Pelvis Views- The non-visualized portion cannot be fully cleared without additional radiographs. Similar old left inferior pubic ramus fracture. Conclusion: 1. Moderate bilateral hip arthrosis. No obvious or acutely displaced fracture given only a single view. 1. Without an orthogonal view, a nondisplaced out of plane fracture cannot be excluded. Additionally, due to positioning, the right superior and inferior pubic rami are not diagnostically visualized and can therefore not be cleared for an acute finding. 2. Given the history of trauma, there should be low threshold for further evaluation by CT scan. Review of x-rays completed at the hospital on 12/21/24 at 3:32AM revealed: Pelvis View- Findings/Impressions-Diffuse severe bony demineralization reduces anatomic sensitivity. Acute fractures are suggested involving the right superior and inferior pubic rami. Review of the facility's Falls list dated 01/01/24-01/01/25 revealed: Resident was listed on the Incident/Falls List; 3/01/24, 12/20/24. Review of the Resident #2 Fall Risk assessment revealed: the most recent assessments were completed on: 12/26/24-Score 13 indicating resident is at high risk for falls 11/06/24- Score 14 indicating resident is at high risk for falls 09/08/24-Score 17 indicating resident is at high risk for falls (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the Facility's Abuse/ Neglect Log from January 2024-January 2025 revealed: Resident was listed on Neglect Log 12/2024; Resolution: Unsubstantiated Review of the facility in-services revealed: Abuse/Neglect Training-Reviewed, most recently completed for all nursing staff on 12/20/24-12/21/24, 10/17/24-10/30/24, 8/26/24-8/27/24. Accidents/Hazards-Falls, Fractures: Reviewed, most recently completed for all nursing staff on 12/20/24-12/21/24, 10/17/24-10/30/24, 8/26/24-8/27/24. Interview on 01/07/25 at 10:34 AM Director of Nursing (DON) Risk Manager/Grievance Coordinator stated once a fall occurs with a resident, the nurse assesses the resident, provide the care the resident needs in the moment, reach out to the Physician (MD) to inform the MD of the incident, receives any necessary orders from the MD depending on the nature of the fall and the findings of the nurse-pain, discomfort, type of fall, injuries. The MD may order x-rays, resident transport to hospital, neurological checks for the resident etc. The nurse should report the incident/fall as soon as possible after care is rendered to the resident and the resident is safe. In this incident, the nurse did not report the incident in a reasonable amount of time to the MD. The resident fell on [DATE] around 3 AM, Licensed Practical Nurse (LPN) (Staff A) reported the incident on 12/20/24 around 8pm when she arrived for her next shift, she worked the 7PM-7AM shift, and she had the same assignment as the prior shift. Once the incident was reported by Staff A, the MD and family were called, the MD ordered resident to be sent to the hospital, the family declined the MD's orders, the MD ordered x-rays of the hip and pelvic area, the x-rays were inconclusive. After further discussions with the family, they agreed to send the resident to the hospital on 12/21/24. We stayed in communication with the hospital and the family, there was some concern about the resident's hemoglobin and the family later advised us that the resident had a fracture of the right superior and inferior pubic rami. On 12/20/24, Staff A was removed from the schedule; and has not returned to work as of today, we reported the incident as neglect to all the pertinent agencies and personnel. Our investigation concluded that Staff A failed to report the fall in a timely manner, but we could not conclusively report if the untimely reporting of the incident caused any harm to the resident. The 7AM-7PM Registered Nurse (Staff C) reported the resident was acting differently and complained of knee pain, upon further assessment by Staff C, the resident did not complain of any pain, I reached out to the resident's daughter and the daughter stated the resident did not report any issues or pain to her. This incident/fall was reported as neglect because Licensed Practical Nurse (LPN) Staff A did not follow the fall protocols of notifying the MD and other facility staff in a timely manner, the incident was not reported as an adverse incident because the injury was not the fault of the facility, all the necessary fall precautions were in place for the resident, the resident is a high risk for falls based on her fall assessment score which is completed quarterly and as needed, the bed was in lowest position, personal items were in reach, rounding was completed at minimum every 2 hours, call lights were being answered immediately, and bilateral floor mats were in place. This resident and the family were educated on fall precautions and the importance of calling for assistance for toileting and transfers when needed. The resident also participates in activities throughout the day at the facility and is closely monitored by staff. The resident was readmitted to the facility on [DATE] with a diagnosis of Acute superior and inferior pubic rami fracture with hematoma in the right hemipelvis. Plan of care: Non-surgical management, Physical therapy, Occupational therapy, and pain control. On 1/7/25 at 11AM, attempted to contact Staff A via phone, a message left for a return call. (continued on next page)

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