STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105519	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nspire Healthcare Plantation	6931 W Sunrise Blvd Plantation, FL 33313

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31746 Based on observation, records review, and interviews, the facility failed to ensure it timely answered call lights in response to residents' needs for 3 of 24 sampled resident, Residents #13, #38, and #55. The findings included: 1. Record review revealed Resident #38 was admitted to the facility on [DATE]. On the most recent Minimum Date Set (MDS) assessment, the Brief Interview for Mental Status (BIMS) was documented as a score of 15 of 15, indicating the resident was alert and oriented to person, time, and place (cognitively intact). On 08/20/24 at 1:25 PM, an interview was conducted with Resident #38 who stated she had voiced multiple complaints regarding the call light response to staff. Resident #38 said at times when the call lights is activated, the Certified Nursing Assistant (CNAs) could be observed passing by the room, but they do not bother to come in the room to check. Resident #38 complained that this situation is usually worse on the weekend. In a followup interview with Resident #38 on 08/21/24 at 11:07 AM, during the environmental tour with the Maintenance Staff and Housekeeping Staff present, Resident #38 reiterated that at times, it takes staff 45 minutes to one-hour to answer the call light. Resident #38 stated that the concerns have been reported to the nurses. Resident #38's call light was checked at this time, and it was noted to be functioning well. 2. Record review revealed Resident #13 was admitted to the facility on [DATE]. Review of the MDS revealed the BIMS score was 15 of 15, indicating intact cognition. On 08/19/24 at 10:20 AM, Resident #13 stated the call lights are not answered on time, especially during the night or the 11:00 PM to 7:00 AM shifts. Resident #13 said it sometimes takes 30-60 minutes to have the call light answered. On 08/21/24 at 10:56 AM during the environmental tour, Resident #38 restated the concern regarding call light response, especially at night. Resident #38 said that the call light response time was a chronic situation. Resident #38 stated she had complained to the Director of Nursing (DON) many times regarding that issue. Resident #38 said this issue was also discussed during resident council meetings. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Record review revealed Resident #55 was admitted to the facility on [DATE]. Review of the BIMS score for Resident # 55 noted the score was 1 of /15 indicting intact cognition. On 08/19/24 at 11:42 AM, Resident #55 also stated that the call light is usually answered about an hour later, especially at night during the 11:00 PM to 7:00 AM shifts. During a follow-up interview with Resident #55 on 08/21/24 at 10:49 AM, Resident #55 said she usually used the call light when she needed to be changed. When questioned about the time the interview was being conducted with the surveyor, Resident #55 answered correctly, stating the exact time observed on the clock on the wall.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49060 Based on observations, interviews, and record review, the facility failed to follow the physicians' orders for wound treatment and failed to provide wound care in a timely manner for 1 of 2 sampled residents, reviewed for wound care, Resident #18. The findings included: Record review for Resident #18 revealed the resident was admitted to the facility on [DATE] with the following diagnoses: Acute Osteomyelitis, Left ankle and Foot; Acquired absence of other left toe(S); Type 2 Diabetes Mellitus; and Dependence on Renal Dialysis. Review of Section C of the Minimum Data Set (MDS) dated [DATE] revealed Resident #18 had a Brief Interview for Mental Status (BIMS) of 15, which indicated that he was cognitively intact. Review of Section M revealed that Resident #18 had one unstageable pressure injury presenting as a deep tissue injury (DTI), surgical wound. Review of the Physician's orders showed Resident #18 had an order for left dorsal foot and left lateral foot wound, Cleanse with Normal Saline (N/S) apply skin prep to peri wound non border foam abdominal and wrap with Kling; daily on the day shift. Review of the Care Plan dated 06/06/24 documented Resident #18 has a pressure ulcer to left plantar foot wound, left dorsal foot wound, left heel DTI and has a surgical wound to his Left lateral foot, r/t [related to] History of ulcers, Immobility. Goals were to show signs of healing and remain free from infection. Interventions were to administer treatments as ordered and monitor for effectiveness; Assess / record / monitor wound healing daily; report improvements and declines to the MD; Monitor dressing every shift to ensure it is intact and adhering. During an interview conducted on 08/20/24 at 10:36 AM, Resident #18 stated that he had an amputation of left pinky toe and believed that the dressing should be changed daily. He was concerned that the dressing has not been changed recently, and his left heel was bothering him. During an observation conducted on 08/20/24 at 10:40 AM of Resident #18's left foot revealed the foot was wrapped with a Kling dressing, taped and was dated 08/17/24 7-3 shift. Photographic Evidence Obtained. On 08/20/24, review of the August 2024 Treatment Administration Record (TAR) revealed the nurse signed for Resident #18's wound treatment on 08/17/24 and 08/18/24. No signature was recorded for 08/19/24 wound treatment. Review of the Nursing progress note dated 08/17/24 revealed the dressing change was done to Resident #18 lower extremity. The documentation inlcuded, Wound was observed: beefy red area with some bleeding. Resident #18 was medicated prior to dressing change. No other documentation regarding the left foot wound was found after 08/17/24. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 08/21/24 at 3:44 PM with the Wound Care Nurse (WCN). She stated that she has worked at the facility for [AGE] years as the WCN. She noted that on 05/17/24, Resident #18 returned from the hospital after the amputation of the left pinky toe. She stated that the surgical wound was healing nicely, and some redness appeared in the area, and Resident #18 was seen by the wound doctor. She acknowledged that on Monday 08/19/24 she did not see Resident #18's wound nor had she changed the dressing. She noted that the floor nurses are aware to do the wound treatment if she did not. Upon review of the photograph of Resident #18's dressing, the WCN acknowledged that the dressing had not been changed since 08/17/24. The WCN stated that for Resident #18, she did the wound treatment on 08/20/24 and she thought that the old wound dressing was dated 08/19/24.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38349 Based on review of policy and procedure, record review, observation and interview, the facility failed to administer the correct type of Aspirin medication, as per physician's order for 1 of 5 sampled residents observed during a Medication Administration Observation, Resident #94. The findings included: Review of the facility policy and procedure on 08/19/24 at 2:30 PM, titled, Specific Medication Administration Procedures, provided by the facility's Regional Nurse, reviewed May 2022 documented, in part, in the Policy Statement: Administration Procedures for all Medications - To administer medications in a safe and effective manner. Procedures: .C. Review five (5) rights (3) times: 1) Prior to removing the medication package/container from the cart/drawer: a. Check Medication Administration Record (MAR)/Treatment Administration Record (TAR) for order e. Prepare resident for medication administration. 2) Prior to removing the medication from the container. a. Check the label against the order on the [DATE]: After the dose has been prepared and before returning the medication to storage .H. When applicable, explain to resident the type of medication being administered . Record review revealed Resident #94 was admitted to the facility on [DATE] with diagnoses which included Cerebral Infarction due to Embolism of Unspecified Cerebral Artery, Endocarditis and Heart Valve Disorders in Diseases Classified Elsewhere, Non-ST Elevation (NSTEMI) Myocardial Infarction, Presence of Prosthetic Heart Valve, Hemiplegia and Hemiparesis following Cerebral Infarction affecting right dominant side, Cardiomegaly, Hypertension, Anemia, Diabetes Mellitus Type II, Acute Kidney Failure, Syncope and Collapse and Hydronephrosis with Renal and Ureteral Calculous Obstruction. She had a Brief Interview Mental Status (BIM) score of 15, indicating she was cognitively intact. On 07/09/24, the physician's order documented, Aspirin oral tablet Delayed Release 81mg; to give one (1) tablet by mouth one (1) time a day for Coronary Artery Disease (CAD). During a Medication Administration Observation conducted on 08/19/24 at 9:17 AM of Resident #94, Staff F, Registered Nurse (RN), was observed preparing and placing a chewable pink-colored Aspirin 81mg tablet, ordered daily, in the medication cup along with all of the resident's eight (8) other oral medications. She administered all nine (9) medications, in the medication cup to the resident; instead of preparing and administering the yellow-colored Aspirin 81 mg Delayed Release / Enteric coated tablet, as per the physician's order. Staff F did not separate this chewable Aspirin medication into a different cup, and did not first provide any direction to Resident #94 to inform her that the chewable pink-colored Aspirin 81mg tablet (that was incorrectly administered) should have been chewed. Photographic Evidence Obtained. An interview was conducted with Resident #94 on 08/19/24 at 9:35 AM, in which she was asked, in general, how important was to her that she always receive her correct medications, and she indicated that it was very important to her and added that it would bother her if this was not done. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with Staff F on 08/19/24 at 10:15 AM regarding the pink-colored Aspirin Chewable 81 mg, that she was observed administering to Resident #94, instead of the ordred yellow-colored Aspirin 81 mg Delayed Release/Enteric coated tablet. Staff F acknowledged the difference between the two (2) types of Aspirin and indicated that the correct Aspirin medication should have been administered as ordered. During an interview conducted on 08/19/24 at 1:41 PM with the facility Pharmacist, he acknowledged the difference between the yellow-colored Aspirin 81 mg Delayed Release / Enteric coated tablet and the pink-colored Aspirin Chewable 81 mg. The Pharmacist indicated that both medications are the same type of drug, same dosage and same route, but do not have the same methods of absorption. He stated the correct type of Aspirin medication should have been administered as ordered. A side-by-side direct observation and record review was conducted with the facility's Regional Nurse, in which the difference between the two (2) forms of Aspirin were revealed as 1) yellow-colored Aspirin 81 mg Delayed Release / Enteric coated one (1) tablet oral daily; and 2) pink-colored Aspirin Chewable 81 mg one (1) tablet oral daily. They both had the same name, same dosage, same timing and same route, but with the difference being that of color and method of absorption. The Director Of Nursing (DON) acknowledged that on 08/21/24 at 1:41 PM that the correct type of Aspirin medication should have been administered, as ordered, and this was not done.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38893 Based on observations, interviews and record review, the facility failed to prepare and serve food in a sanitary manner in accordance with professional standards for food safety. The findings included: 1. On 08/19/24 at 8:48 AM, during the initial kitchen tour accompanied by Staff A, Cook, the Dietary Manager and the Registered Dietitian (RD), the following were noted: a. the handles of a spoodle and three spatulas were damaged to a point that they were no longer easily cleanable. b. there was an accumulation of food residues on the blade and the mounting bracket of the table mounted manual can opener. c. there was an accumulation of dust on the air conditioning vent over the food assembly area. d. the wall over and around the door to the walk-in cooler was damaged and tiles were missing. 2. The facility's policy, titled, Handwashing / Hand Hygiene, with a reference date of August 2019, documented, in part: this facility considers hand hygiene the primary means to prevent the spread of infections. The policy did not specifically address hand hygiene in the kitchen and for food safety concerns. During the follow up kitchen tour, on 08/21/24 at 10:52 AM, accompanied by the Dietary Manager and the RD/Licensed Deitician, the following were observed: a. Staff B, Dietary Aide, was observed entering the kitchen and proceeded through the kitchen to the locker room, went in the office, and left the kitchen through a back door to go on a break. Upon returning to the kitchen, the Dietary Aide did not perform hand hygiene prior to donning clean single use gloves after her hands had been potentially contaminated. The Dietary Manager acknowledged that she did not perform hand hygiene prior to donning the gloves. b. Staff C, Dietary Aide, was observed walking from the three-compartment sink, where the Dietary Aide was manually washing and sanitizing utensils and equipment, to the hand washing sink, upon reaching the hand washing sink, Staff C used paper towel to dry her hands without washing them and returned to the ware washing area. Staff C was observed returning from the ware washing area and again drying her hands without washing them in the dedicated hand washing sink. Staff C was observed preparing coffee to be served during the lunch meal, then proceeded across the kitchen to answer the telephone, and then returned to the coffee station. Staff C was then observed donning a clean pair of single use gloves without performing appropriate hand hygiene after her hands had been potentially contaminated at any time during the observation. Staff C acknowledged she did not perform hand hygiene prior to donning the gloves. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. Staff D, Dietary Aide, was observed was observed handling a wet floor sign that was on the floor and then proceeded to handle a cart. Staff D was then observed donning a clean pair of single use gloves without performing hand hygiene after her hands had been potentially contaminated. Staff D acknowledged she had not performed hand hygiene prior to donning the gloves. d. Staff A, Cook, was observed cleaning a cart with a wet towel with her bare hands. Staff A then donned a clean pair of single use gloves without performing hand hygiene after her hands had been potentially contaminated. Staff A acknowledged she did not perform hand hygiene prior to donning the gloves. e. Staff E, Dietary Aide, was observed returning to the kitchen from a service area where the ice machine was located. Staff E was observed donning a pair of clean single use gloves without performing hand hygiene after her hands had been potentially contaminated. Staff E acknowledged she did not perform hand hygiene. The surveyor intervened, and the [NAME] and the Dietary Aides were stopped from continuing working and instructed to perform hand hygiene by the Dietary Manager.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49060 Based on observations, interviews, and record review, the facility failed to ensure accurate records related to dressing change for 1 of 2 sampled residents reviewed for wound care, Resident #18; and failed to ensure complete and adequate documentation for 1 of 1 sampled resident reviewed as deceased in the facility, Resident #99. The findings included: Review of the facility's policy titled, Documentation of Progress, dated [DATE], included the following: Documentation of a resident's condition will provide an accurate and timely record of their progress taking into consideration their acuity and length of stay. 1. Record review for Resident #18 revealed that the resident was admitted to the facility on [DATE] with the following diagnoses: Acute Osteomyelitis, Left ankle and Foot; Acquired absence of other left toe(S); Type 2 Diabetes Mellitus; Dependence on Renal Dialysis. Review of Section C of the Minimum Data Set (MDS) dated [DATE] revealed that Resident #18 had a Brief Interview for Mental Status (BIMS) of 15, which indicated that he was cognitively intact. Review of Section M revealed that Resident #18 had one unstageable pressure injury presenting as deep tissue injury (DTI), surgical wound. Review of the Physician's Orders showed that Resident #18 had an order for left dorsal foot and left lateral foot wound: Cleanse with Normal Saline (N/S) apply skin prep to peri wound non border foam abdominal and wrap with Kling; daily on the day shift. During an interview conducted on [DATE] at 10:36 AM, Resident #18 stated he had an amputation of left pinky toe and believed that the dressing should be changed daily. He was concerned that the dressing had not been changed recently, and his left heel was bothering him. During an observation conducted on [DATE] at 10:40 AM of Resident #18's left foot revealed the foot was wrapped with a Kling dressing and the tape was dated [DATE] ,d+[DATE] shift. Photographic Evidence Obtained. On [DATE], review of the August Treatment Administration Record (TAR) revealed that the nurse signed for Resident #18's wound treatment on [DATE] and [DATE]. No signature was recorded for [DATE] wound treatment. On [DATE], review of the August TAR revealed the Wound Care Nurse (WCN) signed on [DATE] and [DATE] acknowledging that Resident #18 received wound treatment on those days. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on [DATE] at 3:44 PM with WCN. She acknowledged that on Monday [DATE] she did not see Resident #18's wound nor changed the dressing. She noted that the floor nurses are aware to do the wound treatment if she does not. In addition, the WCN stated that for Resident #18, she did the wound treatment on [DATE] and she thought that the old wound dressing was dated [DATE]. She acknowledged signing in the TAR for the treatment on [DATE] even though she did not change the dressings that day. 2. Record review for Resident #99 revealed that the resident was admitted to the facility on [DATE] with the following diagnoses: Acute on Chronic combined systolic (congestive) and Diastolic (Congestive) Heart Failure; Congestive Obstructive Pulmonary Disease; Atherosclerotic Heart Disease of Native Coronary Artery without Angina Pectoris Cardiomyopathy; Dementia; and Personal History of Malignant Neoplasm of Breast. Review of Section C of the Minimum Data Set (MDS) dated [DATE] revealed Resident #99 had a Brief Interview for Mental Status (BIMS) score of 15, indicating she was cognitively intact. Review of Section GG revealed that Resident #99 required partial / moderate assistance for all her Activities of Daily Living (ADLs) and had a wheelchair. Review of Section J revealed that Resident #99 was not under Hospice Care. Review of the Physician's Orders showed that Resident #99 had an order for Advanced directive, Do Not Resuscitate (DNR). Review of the Recreational Services Note dated [DATE] documented Resident #99 preferred to be in her room watching TV and to maintain daily routine of reading and relaxing with her husband. Review of the Psych note dated [DATE] documented Resident #99 had a history of multiple medical problems and increased depression. She was cooperative with care and remains motivated to get well. Review of the Nursing Progress note dated [DATE] documented Resident #99 expired at 12:30 PM, MD [Medical Doctor] and Family notified, but no documentation recorded on [DATE] into [DATE]. An interview was conducted on [DATE] at 1:45 PM with Social Services Director. He stated that he was not aware that the nurses only documented that in their notes (referring to the note dated [DATE]). He acknowledged Resident #99's daughter was at the facility when the resident passed, but he did not write any documentation regarding Resident #99's passing. An interview was conducted on [DATE] at 2:50 PM with the Director of Nursing (DON). She stated that she was not in the facility when Resident #99 expired. She acknowledged Resident #99 was doing well and no health declined noted prior to [DATE]. She noted that Resident #99 was provided care on that day as documented in the Task by the Certified Nursing Assistant (CNA). She dis not have any other documentation of what transcribed on [DATE]. She stated that she was very upset with the nurse because of the lack of documentation on the passing of Resident #99.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49060 Based on observations, interviews, and record review, the facility failed to follow Enhanced Barrier Precautions (EBP) during medication administration for 1 of 11 sampled residents reviewed for EBP, Resident #53; failed to ensure Personal Protective Equipment (PPE) gowns were available on the 2nd floor for 8 of 11 residents who were on EBP; failed to have appropriate signage posted to indicate precautions for 1 of 11 sampled residents reviewed for EBP, Resident #53; failed to properly utilize hand hygiene and discard a used lancet after Blood Glucose check during medication administration observation for 1 of 1 sampled resident, Resident #3; and failed to ensure a sanitary environment during perineal care for 1 of 1 sampled resident reviewed for Urinary Tract Infection (UTI), Resident #56. The census at the time of the survey was 90 residents. The findings included: Review of the facility's policy, titled, Enhanced Barrier Precautions, dated 09/01/22, included in part the following: EBP [Enhanced Barrier Precautions] is used to reduce the spread of Multidrug-Resistant Organisms (MDROs) among residents by utilizing gloves and gowns for high contact resident care activities. Procedure: 1. Identify residents who are appropriate for EBP including: b. Residents who have a wound and/or indwelling medical devices. 2. Place an identification outside the resident room to include type of precaution, required PPE [Personal Protective Equipment], and high-contact areas that require use of PPE. 4. Educate the staff on EBP including but not limited to: a. Use of PPE b. High-contact care activities. Review of the facility's policy, titled, Hand Hygiene, dated 02/05/21, included iin part the following: Hand hygiene should be performed: After contact with inanimate objects (including medical equipment) in the immediate patient vicinity. After glove removal. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Record review for Resident #53 revealed the resident was admitted to the facility on [DATE] with the following diagnoses: Dysphagia following Cerebral Infarction; Type 2 Diabetes Mellitus with Hyperglycemia; Gastrostomy status; and Hypoxic Ischemic Encephalopathy. Review of Section C of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #53 had a Brief Interview for Mental Status (BIMS) score of 10, indicating moderate cognitive impairment. Review of the Physician's Orders showed Resident #53 had an order dated 08/16/24 for Nothing by mouth (NPO) every shift for PEG [Percutaneous Endoscopic Gastrostomy] Tube; Enteral feed order every shift continuous enteral feeding: Glucerna 1.5 at 80ml/hour x 20 hours; Enhanced Barrier Precautions for PEG Tube, every shift (dated 08/19/24). Review of the Care Plan dated 08/16/24 documented Resident #53 required EBP: PEG tube feeding. Goals were for EBP will be maintain for the duration of stay and/or until medical device is discontinued. Interventions were to educate staff on EBP including use of PPE, high contact care activity, hand hygiene, and resident activity; Place an identification outside resident room to include type of precaution required PPE, and high contact areas they require use of PPE. During an observation conducted on 08/21/24 at 8:06 AM, noted Staff L, Licensed Practical Nurse (LPN), entered Resident #53's room. He was observed entering Resident #53's room with medications without donning proper PPE. Further observation revealed Staff L was administering Resident #53's medication via PEG tube without a PPE gown. An interview was conducted on 08/21/24 at 1:28 PM with Staff L who stated he has been working at the facility for 3 years, and was the assigned nurse for Resident #53. Staff L stated EBP is assigned to residents with wounds, PEG tubes, Dialysis sites, etc. he stated EBP signage are placed outside their doors to make sure staff utilize proper PPE. When asked about Resident #53, he stated that the resident should be under EBP because he has a PEG tube and staff would wear PPE only if there was exposure to bodily fluids, however there was no need for PPE during medication administration. During an interview conducted on 08/21/24 at 4:30 PM, the corporate nurse acknowledged that PPE is to be donned during medication administration for residents with a PEG tube. 2. During the initial tour of the facility's 2nd floor conducted on 08/19/24 at 9:40 AM, it was observed that there were 11 brown and white plastic containers in the hallways for the residents on EBP. Further observation of these containers revealed that they were to contain PPE for the EBP residents. The observation revealed there were no gowns noted to be in 8 of these containers. During the morning of 08/19/24, no observation was noted of staff donning on PPE to provide morning care for the residents under EBP. On 08/19/24 at 12:54 PM, another observation was conducted of the PPE plastic containers and no gowns were found in these 8 containers. Again, staff were observed not donning on PPE to provide after-lunch care to the residents under EBP. During an observation conducted on 08/20/24 at 8:44 AM of the 2nd floor of the facility, the PPE plastic containers were inspected and again no gowns were found in the containers. Staff I, Registered Nurse (RN), and the Infection preventionist (IP), noticed the surveyor inspecting the PPE containers and a few minutes later, Staff I was observed stocking the containers with PPE gowns. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105519	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nspire Healthcare Plantation	6931 W Sunrise Blvd Plantation, FL 33313

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 08/20/24 at 9:20 AM with the Director of Maintenance. He stated that it was his fault as to why the PPE kits were not replenished. He acknowledged he received the order for the gowns and did not get the order to Central supply in time for the kits to be restocked on the floor by staff. An interview was conducted on 08/22/24 at 12:33 PM with Staff I, RN. He stated he realized there were no PPE gowns in the plastic containers when he noticed the surveyor looking in the containers on 08/20/24. He stated he is the Infection Preventionist and is responsible for making sure that the containers are restocked, and the Certified Nursing Assistants (CNAs) are the ones that usually stock them. An interview was conducted on 08/22/24 at 1:06 PM with Staff G, CNA, who stated she has been working at the facility for 1 year. She stated that EBP in-service education was recently provided, and PPE is required when providing care to residents with IVs [intervenous], wounds, and PEG tubes. She acknowledged working on Monday 08/19/24 on the 2nd floor and did notice that there were no PPE gowns in the containers. She stated she was not assigned to any residents under EBP and did not require PPE gowns. 3. During the initial tour of the facility's 2nd floor conducted on 08/19/24 at 9:40 AM, obsrvtions noted that several residents had EBP signage posted outside of their doors. Further observation revealed that Resident #53 did not have a EBP signage posted outside of his room. Review of the Physician's Orders showed that Resident #53 had an order dated 08/16/24 for Nothing by mouth (NPO) every shift for PEG Tube; Enteral feed order every shift continuous enteral feeding: Glucerna 1. 5 at 80ml/hour x 20 hours; Enhanced Barrier Precautions for PEG Tube, every shift (dated 08/19/24). During an observation conducted on 08/20/24 at 8:44 AM of the 2nd floor of the facility, Resident #53's room still had no EBP signage posted on the door or anywhere inside the room. During an observation conducted on 08/21/24 at 1:05 PM of the 2nd floor of the facility, Resident #53's room continued without EBP signage posted on the door or anywhere inside the room. During an interview conducted on 08/21/24 at 1:28 PM with Staff L, he stated EBP is assigned to residents with wounds, PEG tubes, Dialysis sites, etc. Staff L stated Resident #53 should be under EBP because he has a PEG tube. At this time, Staff L realized there was no EBP signage posted on Resident #53's door. An interview was conducted on 08/21/24 at 1:36 PM with Staff H, CNA, who stated she has been working at the facility for 4 months, and that Resident #53 was on her schedule assignment. Staff H stated she received in-service education for infection control, but could not recall as to why residents would be under EBP. She noted she follows the instructions on the precaution's signage posted outside of the rooms when providing care to the resident. Staff H acknowledged that there was no EBP sign posted outside of Resident #53's room. (continued on next page)

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	105519	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nspire Healthcare Plantation	6931 W Sunrise Blvd Plantation, FL 33313

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. A medication administration observation was conducted for Resident #3 on 08/20/24 at 4:02 PM with Staff K, LPN, who stated she has worked at the facility for 1 year. Staff K was observed entering the resident's room for a Blood Glucose (BG) check. Upon entering the room, she donned gloves, without performing hand hygiene, and performed the BG check. While holding the used lancet in her left gloved hand, she removed the glove, wrapping the used lancet in the glove, and then held it with her right gloved hand. Staff K walked out of the resident's room still holding the glove-wrapped used lancet in her right gloved hand. She then proceeded to remove the right glove and throw both gloves with the used lancet into the medication cart trash container. Without performing hand hygiene, Staff K moved to her computer and started her documentation. An interview was conducted on 08/20/24 at 5:07 PM with Staff K who was questioned on where she had disposed of the used lancet after the BG check. Staff K stated that she disposed it in the sharp's container on her medication cart. Staff K was asked to check the discarded gloves in her trash container. Without donning gloves, Staff K removed the used gloves from the trash container and found the used lancet inside the gloves. She then discarded the used lancet in the sharp's container. 38349 5. Review of the facility policy and procedure on 08/21/24 at 2:35 PM, titled, Policies and Procedures---Perineal Care, provided by the Director of Nursing (DON) revised 09/05/17, documented, in part, in the Policy Statement: Procedure .Wash, rinse and dry the skin .exposed skin surfaces are soiled Review of the facility policy and procedure on 08/21/24 at 2:45 PM, titled, Policies and Procedures---Personal Protective Equipment Program, provided by the Director of Nursing (DON), revised 03/01/15, documented, in part, in the Policy Statement: Policy the objectives of the Personal Protective Equipment (PPE) Program is to protect employees from the risk of injury by creating a barrier against workplace hazards Record review revealed Resident #56 was readmitted to the facility on [DATE] with diagnoses that included Calculus of Kidney, Severe Sepsis without Septic Shock, Obstructive and Reflux Uropathy, Major Depressive Disorder, Heart Failure, Acute and Chronic Respiratory Failure with Hypoxia, Fracture of Unspecified Part of Neck of Left and Right Femur, Presence of Cardiac Pacemaker, Morbid (Severe) Obesity, Hypertension, and Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Left Non-Dominant Side. the resident's Brief Interview Mental Status (BIMS) score was 15, indicating the resident was cognitively intact. On 08/14/24, a Physician ordered Eccolab Urine Culture documented, Enterococcus Faecium; with a colony count of: >100,000 cfu/ml. On 08/16/24, the Physician's Order Summary Report documented, Nitrofurantoin Monohyd Macro oral capsule 100mg to give one (1) capsule by mouth two (2) times for Urinary Tract Infection (UTI) for seven (7) days. On 07/03/24, the UTI care plan documented, Focus: the resident has a UTI requiring Antibiotics. Interventions: . Good hygiene practices. Goal: the resident's UTI infection will resolve without complications by the review date. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A peri-care observation was conducted on 08/21/24 at 10:10 AM with Resident #56. The resident's pericare was being performed by Staff G, Certified Nursing Assistant (CNA), who washed her hands for 35-40 seconds. Staff G was assisted by Staff H, CNA, who also washed her hands for 35-40 seconds. There was no protective gown donned by Staff G or Staff H prior to performing the peri-care. Staff G raised Resident #56's bed to her (staff) waist level and both Staff G and H went to the bathroom to wash their hands, obtained water (2 basins) for the cleaning, and added some peri-wash soap (Rinse-free) to the water. Staff G again washed her hands and gathered her supplies and donned a clean pair of gloves. It was observed that Resident #56 had had a bowel movement (not cleaned before the periocare). Staff G gently washed Resident #56's peri area from front to back on each separate side of the resident's labia, while the resident was lying on her back. Staff G was observed cleaning the resident, washed her hands, changed her gloves, and used a clean wash cloth and a package of Procare Large Adult Washcloths, and continued to do peri-care. Staff G then cleaned and dried the area 3 separate times. Staff G then removed the old gloves, sanitized and washed her hands, and applied a clean pair of gloves. Staff G turned the resident, cleaned and dried her buttock area from front to back with the Procare Large Adult Washcloths. Staff G obtained 2 clean basins of water, rinsed and dried Resident #56's Peri-area a second time after utilizing the peri-wash and using the Peri-clean spray 3 separate times in the peri-area. Throught the pericare, it was observed that Staff G's long hair braids were unsecured, loose, and hanging down freely in very close proximity to the resident and touching Resident #56's bed sheets, bedding, contaminated diaper and exposed skin, during the peri-care observation. This created the potential for resident-to-employee (vice versa) cross-contamination. Staff G then removed the used gloves, washed her hands, applied a clean pair of gloves and then turned Resident #56 and gently washed her buttock area from front to back, rinsed and then dried the area. She changed the 2 basins of water in between. Staff G was observed replacing Resident 56's diaper, after applying barrier cream to the resident's bottom and peri-area. Staff G then washed her hands for 35-40 seconds. Resident #56's skin was observed with slight redness with mild skin irritation. The resident had expressed this as a concern during the care. On 08/21/24 at 10:50 AM, an interview was conducted with Staff G, Staff H, Staff I, the Second Floor Registered Nurse, Unit Manager, and with Staff J, the covering RN/Director Of Nursing, regarding the above observations. Each acknowledged that staff members hair should not be allowed to come into contact with the resident's exposed skin during procedures. The DON acknowledged on 08/21/24 at 1:28 PM that a sanitary environment should always be maintained during the resident's care to avoid any type of cross-contamination, and this was not done.