STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105596	A. Building B. Wing	11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regents Park at Aventura	18905 NE 25th Ave Aventura, FL 33180

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observations, record review, and interviews, the facility failed to provide adequate privacy during hygiene and catheter care for one resident (Resident #7) out of three residents sampled with an indwelling urinary catheter. Resident #7's roommate entered the room while Resident #7 was exposed. At the time of the survey, nine residents with an indwelling urinary catheter resided in the facility. The findings include. During an observation on November 5, 2025, at 9:45 AM, Staff A, Licensed Practical Nurse (LPN), performed hygiene care for Resident #7. The privacy curtain did not completely extend around the bed, leaving Resident #7 exposed. Additionally, the roommate entered the room while care was ongoing.In an interview conducted on November 5, 2025, at 12:33 PM, Staff A, LPN, was asked about the facility's protocol related to providing privacy during personal care. Staff A acknowledged, I was aware that the curtain did not extend around the resident, but I did not want to stop because I did not want the resident to refuse care. During an interview on November 5, 2025, at 12:51 PM, the Director of Nursing (DON) stated, Staff are to provide privacy to the best of their ability. Record review of a policy titled Promoting/Maintaining Resident Dignity date Implemented: 5/2020 date reviewed/revised: 4/2023 revealed Policy:It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality.Compliance Guidelines:All staff members are involved in providing care to residents to promote and maintain resident dignity and respect residents' rights.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105596	A. Building B. Wing	11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regents Park at Aventura	18905 NE 25th Ave Aventura, FL 33180

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews facility failed to provide appropriate catheter care to facilitate the flow of urine for one (Resident#7) out of three sampled residents who had indwelling urinary catheter, as evidenced by during catheter care Resident#7's indwelling urinary catheter drainage collection bag and tubing were positioned on top of bed with backflowing urine noted in the tubing. This deficient practice prevented the free flowing of urine that would be accumulated in the bladder causing discomfort and increasing the risk for catheter-associated urinary tract infections and other serious medical issues. There were nine residents with indwelling urinary catheters residing in the facility at the time of this survey.The findings include. During an observation on 11/05/25 at 9:45 AM, Staff A, a Licensed Practical Nurse (LPN), performed hygiene and catheter care for Resident #7. The urinary drainage bag and tubing noted with urine were positioned on the bed next to the resident's feet in level with the bladder, causing backflow of urine. (Photographic evidence). At 10:02 AM, Staff A, LPN lowered the drainage bag, opened the port, emptied the urine into a urinal, and closed the port without cleaning it.A review of Resident #7's demographic sheet revealed the resident was admitted on [DATE] and readmitted on [DATE] with diagnoses that included Hemiplegia and Hemiparesis following cerebral infarction affecting the left non-dominant side.A review of a Significant Change Minimum Data Set reference dated 9/13/25 indicated that Resident #7 had a Brief Interview for Mental Status score of 5 out of 10, suggesting severe cognitive impairment.A review of Resident #7's physician's order sheet revealed an order dated 10/28/25 to always keep the urine collection bag below the level of the bladder.On 11/5/25 at 12:33 PM Staff A, LPN stated: the urinary drainage collection bag should be placed in the dignity bag and hooked on the bed frame to help urine flow to prevent urine from going back into the bladder which can contribute to a Urinary Tract Infection (UTI). During care it is okay to leave the drainage bag on the bed because I wanted to prevent any trauma .That positioning could cause reflux due to the kinking; I am supposed to clean the port with an alcohol pad before and after draining the urine to prevent infection.On 11/05/25 at 12:03 PM, the Infection Control Preventionist revealed staff must ensure the urinary drainage bag does not touch the floor and must hang by gravity to maintain a good flow and prevent stasis, which can contribute to UTI due to backflow of urine. When emptying the urine bag, the exit port should be cleaned with soap and water before and after to prevent infection.During an interview on 11/05/25 at 12:51 PM, the Director of Nursing (DON) stated that the bag should remain below the level of the bladder to prevent urine reflux, which can cause a UTI. The staff left the urinary drainage collection bag on the bed during hygiene care to prevent any trauma. The DON noted that there was no facility policy regarding the correct positioning of the indwelling urinary catheter drainage bag and that it is common knowledge.