

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  105596	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/01/2024
NAME OF PROVIDER OR SUPPLIER  Regents Park at Aventura		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41837</b></p> <p>Based on observations, interviews and record review the facility failed to treat residents in a dignified manner who wear adult briefs for 2 out of 40 sampled residents (Residents #72 and Resident #136 and failed to ensure that residents are treated in a dignified manner with bedding while in bed for 1 out of 40 sampled residents (Resident #154) and failed to treat residents in a dignified manner during dining observation (Resident #6).</p> <p>The findings included:</p> <p>Review of the facility's policy titled, Promoting/Maintaining Resident Dignity During Mealtimes dated 03/2020 included in part the following:</p> <p>8. Ensure the resident receives the proper tray.</p> <p>11. Allow adequate time that resident requires to complete meal. Do not rush.</p> <p>12. Allow resident time needed to complete as much as desired of the meal.</p> <p>Review of the facility's policy titled, Promoting/Maintaining Resident Dignity with a revised date of 04/2023 included in part the following: 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.</p> <p>1)Record review for Resident #72 revealed the resident was admitted to the facility on [DATE] with diagnoses including: Polyneuropathy Unspecified, and Benign Prostatic Hyperplasia Without Lower Urinary Tract Symptoms, Urinary Tract Infection Site Not Specified.</p> <p>Review of the Minimum Data Set for Resident #72 dated 07/11/24 revealed in Section C a Brief Interview of Mental Status score of 14 indicating a cognitive response.</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 0550</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 #72 dated 04/18/24 with a focus on the resident has a self-care deficit and needs staff assistance to perform and complete ADL's secondary to: decreased mobility, incontinence status and polyneuropathy. The goal was for the resident to show improvements in his ADL functions with assistance through the next review date. The interventions included: Provide assistance only in the areas difficult for the resident. Allow the resident to do for self as much as possible. Setup needed basic items, washcloth, soap/water, towel, comb, etc. and keep within easy reach daily and as needed. Shower and/or shampoo hair according to patient preference as scheduled and PRN.</p> <p>Review of the Care Plan for Resident #72 dated 04/18/24 with a focus on the resident is at risk for alteration in skin integrity due to decreased mobility, medication side effects and incontinence status of bowel and bladder functions. The goal was for the resident's skin will remain intact through next review date. The interventions included: Apply skin moisturizer/barrier creams after incontinence care. Avoid massage over bony prominences. Change promptly when wet or soiled. Incontinence care - manage moisture.</p> <p>Review of the Care Plan for Resident #72 dated 04/18/24 with a focus on the resident is incontinent of bowel and bladder functions related to decrease mobility. The goal was the resident will be kept clean and dry as possible by next review date. The interventions included: Check every 2-3 hours for wetness/soiling and change promptly. Cue/check and assist to the bathroom/bedpan/urinal upon waking, before and after each meal, at HS (bedtime) and PRN (as needed).</p> <p>During an interview conducted on 07/29/24 at 11:05 AM with Resident #72 who stated staff sometimes take their time coming when he calls for assistance, by the time they come he cannot hold it and cannot help but soil himself. They always help him when he is soiled, it depends on who is working and where he is at, it may take an hour or so. The resident said he has to wear 2 diapers, or he would go all over the place, because he cannot hold his urine. The resident pulled his shirt up and his pants down to show the surveyor how he has to wear 2 diapers, the diapers were taped together to fit the resident who had a large waist. When asked if he was made to wait in a wet diaper, he said the diaper holds the urine and he need two of them or it (the urine) would go all over the place. The resident said sometimes he wets himself in the dining room.</p> <p>2 Record review for Resident #136 revealed the resident was admitted to the facility on [DATE] with diagnoses including: Legal Blindness as Defined in USA, Type 2 Diabetes Mellitus with Unspecified Diabetic Retinopathy without Macular Edema, Chronic Kidney Disease Stage 3 Unspecified.</p> <p>Review of the MDS for Resident #136 dated 07/01/24 revealed in Section C a BIMS score of 15 indicating a cognitive response. In Section H for Urinary continence was documented as always.</p> <p>Review of the Care Plan for Resident #136 dated 07/11/24 with a focus on the resident a has impaired vision and is at risk for decline in visual status. Related to: Diabetic Retinopathy and Legally Blind. The goal was for the resident to maintain self-identity and dignity daily through the next review date. The interventions included: Anticipate and meet needs. Attempt to keep personal belongings in the same and easy access location. Keep room and hallway free of hazardous objects and clutter</p> <p>(continued on next page)</p>		

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<p>F 0550</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 #136 dated 07/11/24 with a focus on the resident is incontinent of bowel and/or bladder as evidence by: Always incontinent. The goal was for resident to be kept clean and dry as possible by next review. The interventions included: Allow resident enough time for B and B needs. Apply skin moisture barrier post incontinence care. Avoid a hurried, judgmental manner. Check every 2-3 hours for wetness/soiling and change promptly.</p> <p>During an interview conducted on 07/30/24 9:25 AM with Resident #136 who said some staff have her wear 2 pampers to catch her urine because she has urine problems. When asked if this is something she requests, she said no, it what the staff do, some staff put 1 pampers on her and some put 2. When asked if she is wet in only 1 brief what happens, she said they just remove the one that is wet</p> <p>49060</p> <p>3) Record review for Resident #154 revealed that the resident was admitted to the facility on [DATE] with the following diagnoses: Alzheimer's Disease, Anxiety Disorder, and History of Falling.</p> <p>Review of Section C of the Minimum Data Set (MDS) dated [DATE] revealed that Resident #154 had a Brief Interview for Mental Status (BIMS) of 99, which indicated that she was rarely/never understood. Review of Section GG revealed that Resident #154 was dependent on the staff to be transferred from the chair to her bed and for all her activities of daily living (ADLs).</p> <p>During the facility's second-floor tour on 07/29/24 at 10:56 AM an observation was conducted of Resident #154's room. Upon entering the room, it was noted that all three beds in the room were without sheets or blankets. In addition, there were two large clear plastic bags filled with linens (unsure if the linens were soiled) located on the floor near the bathroom. Further observation revealed Resident #154 was in her bed without any sheets or a blanket. Resident #154 was dressed; she was on her right side in a fetal like position, which gave the appearance that she was cold.</p> <p>An interview was conducted on 07/31/24 at 9:50 AM with Staff C, Certified Nursing Assistant (CNA). She stated that she has worked at the facility for [AGE] years. Staff C noted that Resident #154 is dependent on staff for all her ADLs, and she is unable to transfer from her wheelchair to the bed on her own. Staff C acknowledged that she was working on Monday (07/29/24) and Resident #154's room was part of her assignment. However, Staff C stated that on Monday, another CNA (Staff F) assisted her with the room (removal of the linens from the beds) and provided care for Resident #154. Staff C stated that she asked Staff F if she had finished with Resident #154's room, and Staff F stated yes. However, Staff C noticed that the surveyor had gone into Resident #154's room. Then, Staff C went into the room and realized that the beds did not have any sheets on. In addition, she observed Resident #154 in her bed without sheets or a blanket, and the dirty linens were in bags on the floor near the bathroom. She also stated that she would never leave her residents in their beds without sheets or a blanket because it is not per policy.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on 08/01/24 at 10:24 AM with Staff F, CNA. She stated that she has worked at the facility for [AGE] years. She noted that she worked on Monday (07/29/24) however, was not assigned to Resident #154's room, but was helping Staff C with her assignment. Staff F acknowledged that on Monday she provided care for Resident #154 and removed the soiled linens. She stated that she left Resident #154 in her bed and the soiled linens for Staff C to finish because Staff C mentioned that she was coming right back. She stated that Staff C had gone to fill the water jug dispenser. Staff F was asked if leaving the resident in the bed without sheets was part of the care, she stated that it depends on the situation. She stated that if the staff is coming right back to finish the resident's care, then it is okay to leave the resident on the bed without linens.</p> <p>40153</p> <p>4) Record review revealed that Resident #6 was readmitted to the facility on [DATE] with diagnoses of Type 2 Diabetes, Hypokalemia, and Hyperlipidemia. The 5-day Minimum Data Set, dated dated [DATE] 24 revealed that Resident #6 had a Brief Interview for Mental Status (BIMS) of 99, which indicated that she rarely/never understood.</p> <p>In an observation conducted on 07/31/24 at 8:35 AM, Resident #6 was noted in her bed with her breakfast tray untouched at the bedside. The breakfast tray was observed with regular pureed nectar thickened liquids, pureed apple cinnamon French toast, pureed oatmeal cereal, cranberry juice, and apple sauce. No staff were noted in the room to help Resident #6 with her breakfast tray. At 9:03 AM (about 30 minutes later), Staff B, Certified Nursing Assistant (CNA), was observed entering Resident #6's room and coming out with the breakfast tray in her hands 4 minutes later. The tray was observed with 100% of the French toast consumed and 25% of the oatmeal consumed.</p> <p>In an interview conducted on 07/31/24 at 10:57 AM, Staff B stated that she is not familiar with Resident #6, that she is new to her, and that she has not worked with her in the past. She said that she only picked up the tray from Resident #6's room and did not assist Resident #6 with her breakfast tray. Staff B reported that Staff A, a Certified Nursing Assistant (CNA), assisted Resident #6 with her breakfast meal.</p> <p>In an interview conducted on 07/31/24 at 11:05 AM with Staff A, she stated that she was assigned to Resident #6 this morning, but she was busy feeding two other residents who needed assistance during dining. Staff A further said that Staff B fed Resident #6 her breakfast meal.</p> <p>In an interview conducted on 08/01/24 at 10:30 AM with the facility's Administrator, she was told of the findings.</p> <p>01948</p> <p>5) During the observation of the breakfast meal on 08/31/24 at 8:15 AM on the 2 East Unit the surveyor was attempting to identify resident's who had not yet received a breakfast meal tray. Specifically resident rooms [] for 6 residents. The surveyor asked the LPN medication nurse ( Staff N) who was in the hallway during the observation stated aloud if the residents have not received the breakfast meal it is because they are feeders another CNA (Staff L ) who was located in the area; also stated aloud in the hallway to the nurse that she was correct and said the residents are.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>feeder. residents are feeders. The surveyor informed the staff that identifying residents as feeders is a dignity issue and to please refer to the residents as requiring assistance with eating.</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>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**</b> 01948</p> <p>Based on observation, interview, and record review, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a safe, orderly, and comfortable interior on the facility's first floor, second floor residential units, third floor residential units, maintenance department, and laundry area.</p> <p>The findings included:</p> <p>During the initial resident screenings conducted by the surveyors on 07/29/24 to 7/30/24 and environment rounds conducted on 07/31/24 and 08/01/24 accompanied with the facility's Director Of Housekeeping and Corporate Director of Housekeeping, the following were noted:</p> <p>1) First Floor:</p> <p>Hallway - Ceiling mounted air -conditioning vents (4) noted to be covered with condensation and dripping onto hallway floor near skilled therapy department.</p> <p>Maintenance Department - During the 08/01/24 tour it was noted that the entry door to the room was proper fully open and no staff within the room and area. Noted that residents have access to hallway where the maintenance department is located, and the room was noted to be full of leaning and poisonous chemical as well as numerous sharp tools.</p> <p>2) Second Floor (East &amp; [NAME] Nursing Units)</p> <p>East &amp; [NAME] Nurses Station - station floor heavily soiled and areas of dried black matter. Furniture and storage cabinets were dust laden.</p> <p>room [ROOM NUMBER] - The privacy curtain (A-bed) did not provide full privacy for the resident, and exterior of foot of the bed (A-bed) was in disrepair.</p> <p>Room # 214 - The privacy curtain (B-bed) did not provide full privacy for the resident, and rooms windows (2) covered with green type algae.</p> <p>room [ROOM NUMBER] - The privacy curtain (B-bed) did not provide full privacy for the resident, and offensive triune odor throughout the room.</p> <p>room [ROOM NUMBER] - Large black stains on the room ceiling tiles (3).</p> <p>room [ROOM NUMBER] - Bathroom toilet requires recaulking to the floor, bathroom paper towel dispenser to working, room windows covered with green type algae. Exterior of bathroom entry door damaged and in disrepair, resident dentures on overbed table, and resident toothbrushes and combs in sink and not in personal protective containers.</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 [ROOM NUMBER] - Bathroom entry door exterior damaged and in disrepair, and bathroom toilet seat loose.</p> <p>room [ROOM NUMBER] - Room floor was soiled and numerous black stains, and wall a/c vent soiled and molded.</p> <p>room [ROOM NUMBER] - Room floor was soiled, exterior of bathroom toilet was soiled, and full urinal container on room floor.</p> <p>room [ROOM NUMBER] - Bathroom emergency call bell wrapped around wall handrail., wall mounted air-conditioning vent leaking steadily onto to the room floor, and the privacy curtain (B-bed) did not provide full privacy for the resident.</p> <p>room [ROOM NUMBER] - Wall air-conditioning vent leaking and condensation steadily dripping onto the room floor.</p> <p>room [ROOM NUMBER] - Bathroom entry door exterior was damaged and in disrepair.</p> <p>room [ROOM NUMBER] - Strong urine odor throughout the room, and bathroom entry door exterior was aged and in disrepair.</p> <p>room [ROOM NUMBER] - Room floor soiled, room entry door exterior was damaged and in disrepair, and no pull cord to over-bed light (A-bed).</p> <p>room [ROOM NUMBER] - Room entry door damaged and in disrepair (sharp exposed edges).</p> <p>room [ROOM NUMBER] - Bathroom emergency call cord wrapped around wall handrail.</p> <p>East Community Shower - Stall #2 had broken wall and floor tiles (5), and privacy curtain soiled with black matter.</p> <p>West Community Shower Room - rusted plumbing pies coming from floor.</p> <p>Biohazard Room - entry door damaged and in disrepair.</p> <p>3) Third Floor:</p> <p>room [ROOM NUMBER] - Bathroom paper towel dispenser not working and would not dispense paper towels.</p> <p>room [ROOM NUMBER] - Bathroom paper towel dispenser not working and would not dispense paper towels.</p> <p>room [ROOM NUMBER] - Privacy curtain (Bed -B) too short to promote privacy for the resident.</p> <p>room [ROOM NUMBER] - Privacy curtain (Bed -B) too short to promote privacy for the resident.</p> <p>room [ROOM NUMBER] - Privacy curtain (Bed -B) too short to promote privacy for the resident.</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>4) Laundry Room: During the observation tour it was noted that a Laundry Aide (Staff H) was sitting directly on a clean linen shelf drinking a beverage. The clean linen folding table was noted to have a phone charging on top of the table and along with beverage containers (3), soiled food containers (2) and staff personal items (purses). Numerous ceiling tiles (3) located in the washroom area were noted to be stained brown in color.</p> <p>5) During an interview conducted with the Housekeeping Director and Corporate Housekeeping Director following 08/01/24 tour it was noted that there is a Maintenance/Housekeeping Logbook located at the 2 nurses station on the second floor and 1 on the third-floor nurses station. Staff are required to log any housekeeping/maintenance issues. The logs are to be viewed during the day by housekeeping and maintenance staff for repairs/cleaning. Further stated that staff are not documenting housekeeping/maintenance issues into the logbooks.</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, it was determined that the facility failed to provide necessary care and services so that activities of daily living do not diminish for 1 (Resident #64) of 5 sampled resident for nutrition review for independence in self-feeding and 1 (Resident #177) of 1 sampled resident for daily dental care.</p> <p>The findings included:</p> <p>1) Observation of the breakfast meal on 07/31/24 at 7:45 AM noted breakfast tray delivered to the room of Resident #64. Mechanical Soft tray served and set up on overbed table in front of resident. Resident not positioned and noted to be in almost a lying position in front of the meal tray. Resident noted to be attempting to feed self with hands and spilling foods on chest/gown. Resident unable to reach beverages on tray and could not drink liquids (juices, milk, coffee) provided on the meal tray. Resident noted with no supervision or assistance from staff during the entire meal observation and consumed less than 50% of the meal and 0% of fluids.</p> <p>Review of Resident #64's clinical records on 07/31/24 noted the following:</p> <p>Revealed the resident was admitted [DATE]. Diagnoses included: Sepsis (4/15/24), Acute Respiratory failure (4/15/24), Diabetes Mellitus type 2 (DM2), Dysphagia, Alzheimer's Disease and Anemia,</p> <p>Review of Resident # 64's Weight History noted steady weight loss:</p> <p>07/24/24 = 156 pounds</p> <p>05/29/24 = 159 pounds</p> <p>04/13/24 = 161 pounds</p> <p>04/04/24 = 169 pounds</p> <p>BMI (Body Mass Index) = 21.8</p> <p>Height = 71 inches</p> <p>Review of the quarterly MDS dated [DATE] documented in section C for cognitive pattern a Brief Interview of Mental status (BIMS) score of 5 out of 15 suggests severe cognitive impairment</p> <p>Section D for Mood documented no mood and section GG for functional abilities documented the resident requires assistance with meals.</p> <p>review of Progress Note dated 7/16/24 documented a weight of 156 pounds, triggers for significant weight loss, =7.8% (13.2 pounds) BMI = 21.8 denotes health range for height.</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>Nutritional Risk assessment dated [DATE] noted: Less (&lt;) Supervision with Meals /Pocketing holding foods in mouth.</p> <p>41837</p> <p>2 Record review for Resident #177 revealed the resident was admitted to the facility on [DATE] with diagnoses including: Encounter for Other Orthopedic Aftercare and Unspecified Dementia.</p> <p>Review of the Minimum Data Set for Resident #177 dated 07/20/24 revealed in Section C a Brief Interview of Mental Status score of 6 indicating severe cognitive impairment.</p> <p>On 07/29/24 at 12:15 PM an observation was made of Resident # 177 lying in bed sleeping with top denture out of mouth on top of bedspread, bottom denture with greenish brown on them were in clear plastic container with opaque liquid covered with a lid (Photographic Evidence Obtained).</p> <p>On 07/29/24 at 3:50 PM an second observation was made of Resident # 177 lying in bed awake with top denture and bottom denture (bottom denture still with greenish brown on them) were in clear plastic container with opaque liquid covered with a lid.</p> <p>During a side-by-side observation conducted on 07/29/24 at 3:50 PM with Staff M Registered Nurse/Unit Manager (RN/UM) who was asked about the dentures for Resident #177, she said the Certified Nurse Aides (CNA) take the dentures out at night and put them in the resident's mouth in the morning. When asked if they are cleaned, she said yes, the CNAs clean the dentures. When asked about Resident #177's dentures in the cup at the bedside, she said it might be some adhesive residue and a denture tablet that turned the adhesive green. When asked if she would wash the bottom denture, she did so in the bathroom and the greenish-brown film came off easily with a toothbrush.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41837</p> <p>Based on observations, interviews, and record reviews the facility failed to ensure resident's room free of accident hazards (razors at bedside) for 1 of 40 sampled residents (Resident #382).</p> <p>The findings included:</p> <p>Review of the facility's policy/procedure titled, Safety Awareness (Sharp Objects) dated 03/01/21 included in part: To ensure the safety and well-being of residents, staff, and visitors by regulating the possession and use of sharp objects and razors within the nursing home facility. For the safety of all individuals within the nursing home, the possession and use of sharp objects and razors by residents are strictly regulated. Sharp objects and razors pose a significant risk of injury and must be managed according to the guidelines outlined below:</p> <p>Definitions:</p> <p>Razors: Bladed instruments used for shaving or cutting hair.</p> <p>Guidelines:</p> <p>1. Prohibited items:</p> <p>Residents are not permitted to possess or use sharp objects or razors independently within the nursing home.</p> <p>Sharp objects and razors include, but are not limited to, knives, scissors, razors (both disposable and electric), needles and other similar items.</p> <p>2. Storage and Access:</p> <p>All sharp objects and razors must be securely stored in designated areas, accessible only to authorized staff members.</p> <p>Record review for Resident #382 revealed the resident was admitted to the facility on [DATE] with diagnoses including: Unspecified Sequelae of Unspecified Cerebrovascular Disease and Hemiplegia Affecting Left Nondominant Side.</p> <p>Review of the Minimum Data Set for Resident #382 dated 06/08/24 revealed in Section C a Brief Interview of Mental Status score of 14 indicating a cognitive response.</p> <p>Review of the Physician's Orders for Resident #382 revealed an order dated 05/30/24 for Clopidogrel Bisulfate (Plavix) Tablet 75 MG Give 1 tablet by mouth one time a day for blood clot prevention related to Cerebrovascular Disease.</p> <p>(continued on next page)</p>		

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<p>F 0689</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 #382 dated 06/12/24 with a focus on the resident at risk for bleeding and easy bruising related to medication regimen. The goal was for the resident to be free from signs/symptoms of bleeding through the next review date. The interventions included: Give medications as ordered. Observe closely for signs/symptoms of bleeding. Provide a safe environment</p> <p>On 07/29/24 at 10:17 AM an observation was made in Resident #382's room on nightstand of safety razor. (Photographic Evidence obtained). The resident was not in the room.</p> <p>On 07/30/24 at 9:40 AM an observation was made of Resident #382 sitting in wheelchair in room with no razor on the nightstand.</p> <p>During an interview conducted on 07/30/24 at 9:40 AM with Resident # 382 who was in his room and asked about a razor seen the day before on his nightstand, he said someone must have come in and took it. The resident proceeded to show the surveyor the drawers in the nightstand by opening each one, in the drawers were approximately 6 to 8 safety razors. When asked if he uses razors, he said yes almost every day.</p> <p>During an Interview conducted on 07/31/24 at 4:00 PM with the Director of Nursing (DON) who stated residents can only have razors to shave, and then the razors need to be disposed of immediately in sharp container.</p> <p>During an interview conducted on 07/30/24 at 9:00 AM with Staff J Licensed Practical Nurse (LPN) who stated she has worked at the facility for 3 years. When asked if residents can have razors at the bedside, she said residents can be provided with a razor, but it must be disposed of after use in sharps container.</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41837</b></p> <p>Based on observations, interviews, and record review the facility failed to monitor weights and identify weight loss in a timely manner for 1 of 10 residents sampled for nutrition (Resident #162).</p> <p>The findings included:</p> <p>Review of the facility's policy titled, Weights (Nutrition) dated 03/01/21 included in part the following: It is the policy of the facility to obtain a weight on all residents at set time intervals and per resident need (daily, weekly, monthly). All residents will be weighed within 24 hours of admission or re-admission and weekly thereafter for an additional 3 weeks, for a total of 4 weeks. The dietician will determine which residents have had a significant weight change (&gt;= 5% loss/gain in 1 month and /or &gt;= 10% loss/gain in 6 months) and a clinical nutrition weight evaluation note will be written in the EMR (Electronic Medical Record).</p> <p>Record review for Resident #162 revealed the resident was originally admitted to the facility on [DATE] with diagnoses that included: Cerebral Atherosclerosis, Type 2 Diabetes Mellitus, Mild Protein-Calorie Malnutrition, Chronic Viral Hepatitis C, Dysphagia Oropharyngeal Phase, and Dementia.</p> <p>Review of the Minimum Data Set for Resident #162 dated 07/19/24 revealed in Section C a Brief Interview of Mental Status score of 99 indicating the resident was unable to complete the interview.</p> <p>Review of the Residents weights revealed the following:</p> <p>On 04/24/24 the resident weighed 175 pounds.</p> <p>For the week of 04/28/24 to 05/04/24 there was no weight for the resident.</p> <p>On 05/06/24 the resident weighed 170.4 pounds.</p> <p>For the week of 05/12/24 to 05/18/24 there was no weight for the resident.</p> <p>For the week of 05/19/24 to 05/25/24 there was no weight for the resident.</p> <p>On 05/30/24 the resident was transferred to the hospital.</p> <p>On 06/06/24 the resident was readmitted to the facility.</p> <p>On 06/07/24 the resident weighed 158 pounds.</p> <p>On 06/10/24 the resident weighed 156.6 pounds.</p> <p>On 06/17/24 the resident weighed 153 pounds.</p> <p>For the week of 06/23/24 to 06/29/24 there was no weight for the resident.</p> <p>(continued on next page)</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>For the week of 06/30/24 to 07/06/24 there was no weight for the resident.</p> <p>On 07/08/24 the resident weighed 140 pounds.</p> <p>On 07/15/24 the resident weighed 135.8 pounds.</p> <p>In summary this indicated the resident did not have a weekly weight for 5 weeks. This also indicated the resident had lost 18 pounds (a significant weight loss of 11.4%) from 06/07/24 to 07/08/24.</p> <p>Review of the Nutritional Risk Evaluations for Resident #162 revealed the resident had a Nutritional Risk Evaluation completed on 06/07/24 and 07/19/24. This indicated there was no Nutritional Risk Evaluation completed in a timely manner after resident had a significant weight loss on 07/08/24 of 11.4%.</p> <p>During an interview conducted on 07/31/24 at 12:00 PM with Staff D Registered Dietician (RD) revealed she has worked at the facility for 3 years. When asked about weights, she said the residents are weighed on admission, then weekly for 4 weeks, then monthly. She said if the resident is having weight loss during the weekly weights, the resident would continue on with weekly weights until the resident no longer had weight loss and the weight was stable. When asked about significant weight loss, she said a significant would be greater than 5% in 1 month (30 days), or greater than 7% in 3 months (90 days), or more than 10% in 6 months (180 days). When asked who is responsible for making sure the weights are obtained and entered into the residents EMR (Electronic Medical Record), she said she is ultimately responsible. When asked if there is any issue with obtaining the weights, she said they have a good system in place to get the weights for residents. When asked about Resident #62, she acknowledged the resident had weight loss, a significant weight loss and they had missed some of the weekly weights.</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41837</b></p> <p>Based on observations, interviews, and record reviews the facility failed to ensure medications secured in med room for one of two med rooms observed and failed to secure medication for 3 of 40 sampled residents (Resident #136, Resident #120, and Resident #382.)</p> <p>The findings included:</p> <p>Review of the facility's policy titled, Labeling of Medications Storage of Drugs and Biologicals with an implemented date of 11/28/19 included in part: It is the policy of this facility to ensure that all medications and biologicals used in the facility will be labeled and stored in accordance with current state, federal regulations.</p> <p>1 On 07/30/24 at 3:55 PM Staff H Registered Nurse (RN) lead surveyor to show where additional isolation gowns were kept, she entered an unlocked room containing multiple over the counter medications including Acetaminophen, zinc, aspirin, Vitamin B12, and ferrous sulfate, in an unlocked treatment cart in the unlocked medication room containing Hydrocortisone Acetate 1%, and in an adjoining room inside the unlocked medication room was another room with the door wide open and no lock on the door, with various creams, ointments and solutions for wound care.</p> <p>During an interview conducted on 07/30/24 at 3:55 PM with Staff H RN who acknowledged the room should be locked. The RN stated it is normally locked. The wound care nurse entered the medication room and was asked if this was her treatment cart, she said yes. When asked if it is normally left unlocked when unattended, she said no, she had been cleaning the cart at the end of her shift and went to throw out some garbage and must have forgotten to lock the cart and also forgot to make sure the medication room was locked.</p> <p>2 Record review for Resident #120 revealed the resident was admitted to the facility on [DATE] with diagnoses including: Wedge Compression Fracture of Second Thoracic Vertebra Initial Encounter for Closed Fracture, Unspecified Fracture of Upper End Left Humerus Initial Encounter for Closed Fracture and Cough Unspecified.</p> <p>Review of the Minimum Data Set (MDS) for Resident #120 dated 06/19/24 revealed in Section C a Brief Interview of Mental Status (BIMS) score of 12 indicating moderate cognitive impairment.</p> <p>On 7/29/24 12:15 PM an observation was made of Resident #120 sitting in wheelchair near bed, on overbed table in front of resident was Biotene dry mouth lozenges.</p> <p>On 7/30/24 10:04 AM a second observation Resident #120 in bed with Biotene dry mouth lozenges on overbed table next to resident.</p> <p>During an interview conducted on 07/29/24 at 12:15 PM with Resident #120 who was asked about the Biotene dry mouth lozenges on her overbed table, she said she uses them at least once a day sometimes twice a day, the medications make her mouth dry.</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>During an interview conducted on 07/30/24 at 10:05 AM with Staff H Registered Nurse (RN) who was asked if resident can have medications at the bedside, she said no. Staff H RN stated: unless the family brought medication in and we did not find it, we are constantly checking to see if residents have medications at the bedside. During a side-by-side observation with Staff H, RN who acknowledged the Biotene dry mouth lozenges on overbed table next to Resident #120. She said the resident should not have them and we can do a self-administration evaluation and call the doctor to see if he wants to order the Biotene for the resident.</p> <p>3 Record review for Resident #136 revealed the resident was admitted to the facility on [DATE] with diagnoses including: Legal Blindness as Defined in USA, Type 2 Diabetes Mellitus with Unspecified Diabetic Retinopathy without Macular Edema, Chronic Kidney Disease Stage 3 Unspecified.</p> <p>Review of the MDS for Resident #136 dated 07/01/24 revealed in Section C a BIMS score of 15 indicating a cognitive response. In Section H for Urinary continence was documented as always.</p> <p>Review of the Care Plan for Resident #136 dated 07/11/24 with a focus on the resident a has impaired vision and is at risk for decline in visual status. Related to: Diabetic Retinopathy and Legally Blind. The goal was for the resident to maintain self-identity and dignity daily through the next review date. The interventions included: Anticipate and meet needs. Attempt to keep personal belongings in the same and easy access location. Keep room and hallway free of hazardous objects and clutter</p> <p>On 07/30/24 at 9:20 AM an observation was made of Resident #136 lying in bed and on the overbed table was Emergen C vitamin C gummies, vitamin C lozenges, Vicks vapor ointment (Photographic Evidence Obtained).</p> <p>During an interview conducted on 7/30/24 at 9:25 AM with Resident #136 who was asked about the medications at the bedside she said they are vitamin C and are like candy. Takes them when she thinks to, and she said she keeps them all on the bedside table. She said nursing has seen them and has no issue with them.</p> <p>During an interview conducted on 07/30/24 at 9:35 AM with Staff J Licensed Practical Nurse (LPN) who stated she has worked at the facility for 3 years. When asked if residents can have medications at the bedside, she said they can self-administer medications if assessed and meds are kept locked at the bedside and there is a care plan. When a side-by-side observation was made in the room of Resident #136, the LPN acknowledged the medications and said, I thought they were candy.</p> <p>During an interview conducted on 07/30/24 at 9:37 AM with Staff K Registered Nurse/Unit Manager (RN/UM) who stated she has worked at the facility for [AGE] years. When asked if residents can keep meds at the bedside, she said residents should not have meds unlocked at the bedside, they need to be assessed to self-administer, and if it is okay for the resident to self-administer, then the meds need to be locked. When asked if Resident #136 was assessed to self-administer medications, she said no.</p> <p>During an interview conducted on 07/30/24 at 9:45 AM with Staff L Certified Nursing Assistant (CNA) who stated she has worked at the facility for 4 months. When asked if residents can have meds at the bedside, she said no, if she sees meds at the bedside, she calls for the nurse to tell them.</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>4 Record review for Resident #382 revealed the resident was admitted to the facility on [DATE] with diagnoses including: Unspecified Sequelae of Unspecified Cerebrovascular Disease and Hemiplegia Affecting Left Nondominant Side.</p> <p>Review of the MDS for Resident #382 dated 06/08/24 revealed in Section C a BIMS score of 14 indicating a cognitive response.</p> <p>On 07/29/24 at 10:17 AM an observation was made in Resident #382's room on nightstand of safety razor, Asper creme, Tums, and 3% Hydrogen peroxide (Photographic Evidence obtained). The resident was not in the room.</p> <p>On 07/30/24 at 9:40 AM an observation was made of Resident #382 sitting in wheelchair in room with no medications or razor on the nightstand.</p> <p>During an interview conducted on 07/30/24 at 9:40 AM with Resident # 382 who was in his room and asked about the Tums and Asper creme at the bedside that was not there today, he said someone must have come in and took it because they are always there. He said the Tums he takes because he has a lot of gas. The resident proceeded to show the surveyor additional medications he had in his nightstand drawer, including Omega 3 Fish oil capsules, and Centrum Men 50 multi-vitamins also noted in the drawers were approximately 6 to 8 safety razors. When asked if he uses razors, he said yes almost every day.</p>		

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<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>01948</p> <p>Based on observation, interview, and record review, it was determined that portion sizes documented on the approved menu were not followed and potentially effected 88 of the facility residents with physician ordered Regular diet.</p> <p>The findings included:</p> <p>During the observation of the lunch meal in the main kitchen on 07//31/24 at 11:45 AM, it was noted that the entree serving of roast turkey appeared insufficient. Further observation noted that all of the individual portions of Roast Turkey (approximately 40) located in steam table appeared insufficient. A review of the facility's approved menu for the lunch meal of 07/31/24 noted documentation that a minimum 3-ounce portion of Roast Turkey was to be served. A portion of the Roast Turkey that was plated to be served was selected by the surveyor to be weighed by the Food Service Director (FSD). The turkey portion weighed on the facility's calibrated food scale was recorded at 2.46 ounces. The surveyor reviewed the approved lunch menu with the FSD that indicated a requirement of 3 ounces minimum turkey portion. It was then requested that a portion scale be utilized on the tray line to ensure that the portion size of 3 ounces was being followed.</p>		

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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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 01948</p> <p>Based on observation, interview, and record review, it was determined that the facility failed to prepare food in a form to designed to meet the individual needs for 31 residents out of which eight included eight sampled residents (Resident #6, Resident #22, Resident #50, Resident #111, Resident #118, Resident #144, Resident #154, Resident #177), and failed to provide 43 residents with physician ordered Mechanical Soft that included sampled Resident #161.</p> <p>The findings included:</p> <p>Review of the facility's Approved Diet Manual (2019) on 07/30/24 noted the following:</p> <p>* Dysphagia Pureed Diet: The diet is used for severe chewing and/or swallowing problems. All foods are pureed to stimulate a a food bolus , eliminating the whole chewing phase. All foods must be the consistency of moist mashed potatoes and/or pudding like consistency.</p> <p>* Mechanical Soft Diet: The diet is used for individuals with mild and/or pharyngeal phase dysphagia. Foods that are difficult to chew are chopped, ground, shredded, cooked, or altered to make them easier to chew. Allfoods that are hard to chewy should be avoided. All protein foods (meats, poultry/fish) must be very tender , chopped or ground, and well moistened.</p> <p>1) During the observation of the lunch meal of in the main kitchen on 07/29/31 at 11:45 AM , it was noted that the 1/3 sized steam table pan of pureed Cilantro Rice appeared to have lumps and pieces. During the observation the surveyor requested to taste the pureed rice mixture and it was noted that there were small pieces of rice in the pureed mixture and the rice was not of a smooth consistency. The FSD and the cook ( staff ) declined to taste the pureed rice to confirm the surveyors findings . Interview with the cook at the time of the observation noted to state no specific training on the preparation of pureed foods and further stated that he does not taste test the various pureed mixtures to ensure a smooth pureed consistency. The surveyor requested the rice be pureed to he required smooth consistency prior to serving residents with physician ordered pureed diet.</p> <p>2) During the observation of the breakfast meal in the main kitchen on 07/30/24 at 7 AM, the surveyor requested a taste test of the pureed eggs. The taste test again noted small pieces of egg with the pureed mixture. Interview with the cook at the time of the observation again noted that the pureed foods are not taste prior to serving to ensure a smooth pureed consistency.</p> <p>* Review of the facility's Diet Census Form dated 07/29/24 noted that there were currently 31 facility resident's with physician ordered Pureed Diet, which included Sampled Resident's #6, #22, #50, #111, #118, #144, #154, and #177.</p> <p>41837</p> <p>2 Record review for Resident #161 revealed the resident was admitted to the facility on [DATE] with a Principle Diagnosis of Cerebral Ischemia</p> <p>(continued on next page)</p>

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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>Review of the Physician's Orders for Resident #161 revealed an order dated 04/11/24 for NAS (No Added Salt) diet, Mechanical Soft texture, thin consistency.</p> <p>On 07/29/24 at 1:05 PM an observation was made of Resident #161 sitting in 3rd floor dining room with large piece of chicken , rice, zucchini, roll and piece of chocolate cake, on the meal ticket was regular mechanical soft, ground Italian baked chicken (Photographic Evidence Obtained).</p> <p>On 07/29/24 at 5:55 PM an observation was made of Resident #161 eating in 3rd floor dining room, on her plate was a slice of vegetable quiche, sauteed spinach, dinner roll, spice pears, baked onion soup. meal ticket stated regular mechanical soft.</p> <p>During an interview conducted on 07/31/24 at 12:00 PM with Staff D Registered Dietician (RD) who was asked about a mechanical soft diet, she said the meat would be ground. When asked about Resident #161, would a whole chicken breast be acceptable for the resident with the mechanical soft diet, she said no, it should be ground. When shown the picture of chicken with meal ticket for Resident #161, the RD stated that is not good.</p> <p>In summary the reviewed diet census for the facility on 07/29/24 and it was noted that there were currently 43 residents with physician ordered mechanical soft diet, of the 43 residents it included Resident #161.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</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> 01948</p> <p>Based on observation, interview and record review, it was determined that the facility failed to store prepare, distribute and serve food in accordance with professional standards for food service safety that potentially effects 164 of the facility residents.</p> <p>The findings included:</p> <p>1) During the initial kitchen/food service observation tour conducted on 07/29/24 at 9:00 AM and accompanied with the facility's Food Service Director (FSD), the following were noted:</p> <p>(a) A large section of the ceiling (8 feet) was noted to be dripping heavily on to the floor area in front of food production table/surfaces and reach-in refrigerators (3). The floor covered in a large area of contaminated water. It was noted that staff were walking through the water and cases of recent food deliveries were also in contact with the water. The FSD stated that the dripping ceiling water was from broken air-conditioning pipes and had been an issue for the past 2 weeks. The surveyor requested that the cases of food be moved to a safe area and the floor area closed off from staff traffic.</p> <p>(b) Observation of the dry food/disposable goods storage area noted that soiled staff clothing and soiled freezer jackets were hung directly on clean storage shelves and in contact with clean disposable goods. The surveyor requested to the FSD to remove the clothing items from the clean storage room.</p> <p>(c) Observation of the walk-in refrigerator #1 noted a 10-pound commercial package of Macaroni Salad. Further observation noted that the commercial container failed to have a stamped expiration date. The surveyor requested the FSD to contact the company to determine the expiration date and provide the documentation.</p> <p>(d) Observation of the food preparation area noted a large electrical box (2 X 3') of which the surface was rust laden. The surveyor requested the FSD to contact the maintenance department to remove the rust from the exterior.</p> <p>(e) Observation of the dairy dish room area noted that racks (3) of soiled resident dishes from the breakfast meal were being stored in a clean area. The surveyor discussed with the FSD that there was potential of cross contamination form soiled dishes to clean food preparation equipment and requested the racks be moved to the soiled area of the dish room.</p> <p>(f) Food utility carts and food transportation carts (3) were noted to have storage shelves that were heavily soiled and areas on black mold type matter. The surveyor discussed with the FSD that the carts need to be properly cleaned and sanitized prior to continued use.</p> <p>(g) Numerous adaptive eating dishes (5 -3-compartment and wide lip plates) were noted to have exteriors that were heavily stained yellow and brown, The surveyor requested that the plates be discarded from continued use.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Regents Park at Aventura		STREET ADDRESS, CITY, STATE, ZIP CODE  18905 NE 25th Ave Aventura, FL 33180	
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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>(h) Observation of the walls and floors of the food production area were noted to be heavily soiled and/or had broken tiles (10). The surveyor discussed with the FSD the walls and floors were not being properly cleaned on a daily basis and that maintenance be contacted for tile repair.</p> <p>(i) Observation of a ceiling vent located next to the 3-compartment sink was noted to have an exterior with a heavy build-up of condensation that was dripping down onto the floor area and clean food production and preparation equipment. The FSD stated that the vent and ceiling issues been reported for weeks to the administration without repair.</p> <p>(2) During a second observation of the lunch meal on 07/29/24 at 11:30 AM accompanied with the FSD, the following were noted:</p> <p>(k) Dietary staff were noted to be handling and bagging clean resident silverware in an unsanitary manner. Specifically, a large dish rack of silver was being stored next to the food tray line. Staff were noted to be handling the clean silverware by the food contact stem resulting in potential contamination. The surveyor discussed that all silverware is to be store in containers with the stem handles in the upright position. The surveyor requested that the silverware be rewashed and sanitized and stored in the regulatory requirement.</p> <p>3) During a third observation of lunch in the main kitchen and accompanied with the Food Service Director on 07/29/24 at 12:15 noted:</p> <p>(a) Temperatures of hot and cold foods on the tray assembly line were tested with the facility's calibrated digital thermometer. The testing revealed that hot foods were not being held at the regulatory temperature of 135 degrees F or greater and cold foods were not being held at the regulatory temperature of 41 degrees F or below:</p> <p>Italian Baked Chicken (30 portions) = 125 degrees F</p> <p>Beef Liver Platter (6 portions) = 60 degrees F</p> <p>Garden Pasta (10 portions) = 45 degrees F</p> <p>[NAME] Slaw (10 portions) = 40 degrees F</p> <p>Orange Juice/Cranberry Juice (30 portions) = 50 degrees F</p> <p>Nectar Thickened Milk (8 portions) = 50 degrees F</p> <p>4) Fourth observation of the breakfast meal conducted in the main kitchen on 07/30/24 at 6:45 AM and accompanied with the Food Service Director (FSD), noted:</p> <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 - Many</p>	<p>(a) Approximately 25 pounds of bagged raw chicken was noted thawing in a large pan that in the cook's sink with running water. Further observation noted that only the hot water valve was open and running onto the raw chicken. A temperature conducted by the Food Service Director was noted to be recorded at 105 degrees F. It was immediately discussed with the FSD that the regulatory requirement is for the water to be running at 70 degrees F or below. The bagged chicken was noted to be almost defrosted and not cold to the touch. The surveyor requested to the FSD that the chicken not be utilized for the lunch meal on 07/30/24. The FSD informed the surveyor that all of the raw chicken was discarded.</p> <p>(b) Temperatures of hot and cold foods on the tray assembly line were tested with the facility's calibrated digital thermometer. The testing revealed that hot foods were not being held at the regulatory temperature of 135 degrees F or greater and cold foods were not being held at the regulatory temperature of 41 degrees F or below; the following was noted:</p> <p>Pureed Oatmeal = 120 degrees F</p> <p>Fortified Oatmeal = 120 degrees F</p> <p>Pureed Eggs = 135 degrees F</p> <p>Pureed Tropical Fruit Salad = 60 degrees F</p> <p>Mechanical Soft Tropical Salad = 60 degrees F</p> <p>(c) Observation of the Meat Dishwashing Room noted that the exterior of ceiling vent located in the middle of the dish washing room was noted to have a heavy accumulation of condensation. Further observation noted that the condensation was dripping down on to clean food transportation carts and clean resident dishes. The surveyor informed the FSD that there was potential for contamination and no carts or dishes should be allowed under the dripping vent and that maintenance department be contacted to resolve the issue immediately.</p> <p>(d) Rodent traps (4) were noted to be located throughout kitchen in food areas. During a discussion with the FSD at the time of the observation she reported to not have knowledge if there was a rodent issue.</p> <p>(e) Flying insects (4) were noted in food production and serving areas of the main kitchen. The surveyor requested the FSD to notify administrator to contact their pest control company for servicing.</p> <p>5) During a fifth observation conducted in the main kitchen on 07/31/24 at 11:30 AM and accompanied with the Food Service Director (FSD) noted:</p> <p>(a) Temperatures of hot and cold foods on the tray assembly line were tested with the facility's calibrated digital thermometer. The testing revealed that hot foods were not being held at the regulatory temperature of 135 degrees F or greater and cold foods were not being held at the regulatory temperature of 41 degrees F or below, the following was noted:</p> <p>Tossed Salad (8 portions) = 58 degrees F</p> <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 - Many</p>	<p>(b) Pan of powdered thickener (2 pounds) failed to be documented with a date.</p>

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>40153</p> <p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>Based on observations, interviews, and record reviews, the facility failed to develop and implement an effective Quality Assurance and Performance Improvement Program (QAPI) with appropriate plans of action. The facility failed to regularly review and analyze data and act on available data to make improvements regarding 4 out of 4 federal repeated deficiencies (F550, F761, F812 and F867).</p> <p>The findings included:</p> <p>A review of the facility QAPI Plan (no date) revealed the following: We will set short-term achievable goals in quarterly increments to allow review of our progress towards our annual long-term goal. We will continually monitor to sustain the goals we have met. Each Performance Improvement Project subcommittee will utilize Root Cause Analysis and the Plan, Do, Study, Act (PDSA) cycle of improvement to improve existing processes. Data will be collected during this process and then analyzed to determine the effectiveness of change. Upon conclusion of each Performance Improvement Project, the subcommittee will provide the QAPI Committee with a summary report, analysis of activities, and recommendations.</p> <p>A review of the last recertification survey dated 03/02/23 revealed that the facility was cited for the following deficiencies: F550 under Resident Rights, F761 under Pharmacy Services, F 812 under Food and Nutrition Services, and F867 under Quality Assurance Performance Improvement.</p> <p>During the QAPI review conducted with the Administrator on 08/01/24 at 9:20 AM, she stated that they meet monthly and review past deficiencies from prior surveys. They will start a QAPI and will reevaluate after the first three months. If a QAPI is not meeting its set goal, it will investigate the root cause analysis and change the action plans until it meets the goal rate, usually at 100%. When asked about the repeated deficiency of F812, the Administrator said that they had identified the condensation issue in the central kitchen but had yet to have a chance to start a QAPI. She discussed sanitation concerns and staff education completed by the kitchen manager but could not provide this Surveyor with any tracking and trending QAPI.</p> <p>Continuing the interview on 08/01/24 at 10:00 AM with the facility's Administrator, she stated that they had issues regarding F550 and staff standing over residents during dining in the last survey. This was resolved, and they do not have any QAPI regarding dignity during dining. She further stated that all department heads were responsible for monitoring dignity during dining and reporting to her. The Administrator reported that she has identified medication at the bedside and that residents are ordering medications online. She has been doing her own monitoring and rounds with other staff members but was not able to provide this Surveyor with the QAPI paperwork regarding tracking and trending on any medications at the bedside or medication rooms not locked.</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** 41837</b></p> <p>Based on observations, interview and record review the facility failed to follow facility policy for 2 out of 31 residents on Enhanced Barrier Precautions (EBP) Residents #177 and #69 as evidenced by no isolation gowns at the residents' doors and failed to ensure that food trash/soiled residents food trays are covered during transportation.</p> <p>The findings included:</p> <p>Review of the facility's policy titled, Enhanced Barrier Precautions with a revised date of 04/01/24 included in part: EBP is intended for nursing homes to prevent the spread of novel or targeted Multi-Drug Resistant Organism (MDRO)s when resident have an infection or colonization with a MDRO or if the resident has a wound or indwelling medical device, regardless of MDRO infection or colonization.</p> <p>Review of the Center for Disease Control (CDC) guidelines documented, in part, that for residents on EBPs that PPE (gowns and gloves) are to be located at the residents' doors. The CDC website is <u>CDC_Implementation_Of_Personal_Protective_Equipment_(PPE_Use_In_Nursing_Homes_To_Prevent_Spread_Of_Multidrug-resistant_Organisms_(MDROs))</u>.</p> <p>1) On 07/29/24 at 12:15 PM an observation was made of Resident #177 lying in bed, resident has EBP sign on door and above her bed, there were no isolation gowns in the room.</p> <p>On 07/29/24 at 3:50 PM a second observation was made of Resident # 177 lying in bed awake, resident has EBP sign on door and above her bed, there were no isolation gowns in the room.</p> <p>During an interview conducted on 07/29/24 at 3:55 PM with Staff M Registered Nurse/Unit Manager (RN/UM) in Resident #177's room, she acknowledged the resident was on EBP for a wound, when asked where the PPE is kept, specifically the gowns, she said they are right next to the inside of the door to the room and as she pointed the area next to the door, she said they must have run out. When asked where additional isolation gowns are kept, she said they are at the nursing station. When asked to show surveyor the extra isolation gowns at the nursing station, she leads the surveyor to the nursing station at the other end of the hallway where they were out of gowns and handed the surveyor off to Staff H Registered Nurse (RN) who proceeded down another hallway almost to the very end across from room [] to an unlocked storage room with the extra isolation gowns. Staff H RN said the room is normally locked.</p> <p>2) On 07/29/24 at 11:50 AM an observation was made of Resident #69 lying in bed with tube feeding bottle full and not infusing, the resident has EBP sign on door and above her bed, there was no isolation gowns in the room.</p> <p>3) On 07/30/24 at 9:55 AM an observation was made of an uncovered meal tray cart containing 10 dirty trays being pushed through the hallway on the 3rd floor by Staff I Dietary Aide.</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 interview conducted on 07/30/24 at 10:00 AM with Staff I Dietary Aide who reported she has worked at the facility for [AGE] years. When asked if she normally pushes a meal tray with dirty trays uncovered down the hall, she said no, but someone must have thrown the cover away.</p>