STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105679	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regents Park of Sunrise	9711 W Oakland Park Blvd Sunrise, FL 33351

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40153 Based on observations, interviews, and record review, the facility failed to provide assistance during dining for 1 of 2 sampled residents reviewed for nutrition (Resident #44). The findings included: Record review revealed Resident #44 was initially admitted to the facility on [DATE] with diagnoses of muscle wasting, anemia, and depression. The Quarterly Minimum Data Set (MDS) assessment revealed Resident #44 has a Brief Interview of Metal Status (BIMS) score of 03, indicating severe cognitive impairment. Section GG of this MDS under eating showed that Resident #44 required supervision with touch-up assistance. In an observation conducted on 04/22/24 at 9:56 AM, Resident #44 was asleep in bed. Closer observation showed a breakfast tray untouched with the following food items: one slice of bread, two pieces of bacon, cereal, and one carton of milk. Continued observation did not show that the staff encouraged or queued Resident #44 to eat her breakfast meal. In an observation conducted on 04/22/24 at 12:06 PM, the staff finished passing all the lunch trays on the B-wing. At 12:07 PM, the Surveyor observed the resident did not have her tray, and asked Staff J, Registered Nurse (RN), why Resident #44 did not get her lunch tray. Staff J then said she would call the central kitchen to request Resident #44's lunch tray. Further observation revealed that her tray arrived from the kitchen at 12:14 PM. The lunch tray consisted of the following food items: Regular diet, chicken parmesan, linguine pasta, broccoli, garlic bread, and a fruit cup. At 12:24 PM, Staff J took the lunch tray untouched from Resident #44's room and left with the tray. In an interview conducted on 04/23/24 at 9:00 AM, Staff K, Certified Nursing Assistant (CNA), stated that Resident #44 ate about 25% of her breakfast meal and can eat independently with no issues. In an observation conducted on 04/23/24 at 11:56 AM, Resident #44 was asleep in her bed. The lunch tray arrived in the room and was placed near her. A continued observation at 12:15 PM revealed the tray untouched, with Resident #44 asleep in the bed. (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation conducted on 04/23/24 at 12:28 PM, Resident #44 was asleep in her bed. The lunch tray was still untouched, and no staff was noted in the room encouraging or attempting to wake her up to eat her lunch meal. In an observation conducted on 04/24/24 at 8:16 AM, Resident #44 was asleep in her bed. At 8:20 AM, Staff L, CNA, brought the breakfast tray into the room and set it up for Resident #44. In this observation, Staff L stated that Resident #44 can eat on her own with no issues and that she usually eats 100% of her meals when she has an appetite. Record review of the CNAs' tasks, under section 'task' for eating, revealed the following: on 04/22/24, Resident #44 ate 26% to 50% of her breakfast meal, and 26% to 50% of her lunch meal, which was not as observed by the surveyor. Review of the weight log revealed that Resident #44's weight was trending down from 149 pounds on 12/06/23 to 141.8 pounds on 04/04/24. A new weight of 139.6 pounds, was taken on 04/24/24. In an interview conducted on 04/24/24 at 10:09 AM with Staff A, Minimum Data Set Coordinator, she stated that Resident #44 is coded for supervision with touch-up assistance for eating. According to Staff A, Resident #44 needs to be watched over, placed tray closer for better access, and may be struggling or trying to reach the food items on the tray. State A stated it also means Resident #44 may need reminders to eat periodically. In an interview conducted on 04/24/24 at 12:00 PM, Staff A stated that she reassessed Resident #44 and that she needed supervision with touch-up assistance during dining.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36734 Based on observation, interview, and record review, the facility failed to address a skin rash for 1 of 1 resident sampled for skin condition, Resident #97; and failed to address new symptoms of a Urinary Tract Infection in a timely manner for 1 of 1 sampled resident, Resident #59. The findings included: 1. Record review documented Resident #97 was admitted to the facility on [DATE]. A comprehensive assessment dated [DATE] documented the resident had severe cognitive impairment, was dependent for activities of daily living, and had a tracheostomy and feeding tube. The record documented Resident #97 was care planned for a rash/itching to upper back on 04/01/24. Interventions included: give anti-pruritic (anti-itching) medications as ordered by physician. Monitor/document side effects and effectiveness. Monitor skin rash for increased spread or signs of infection. Record review revealed an order dated 03/30/24 for Permethrin External Lotion 1 % (medication to treat Scabies) to apply to right lower back topically two times a day for Itching. Review of the progress note dated 03/30/24 at 4:05 PM documented: Resident's family inquire about cream for itching and rash on right lower back. Order received today to start on Permethrin 1% lotion to apply to lower back for itching. Review of Resident #97's Medication Administration Record revealed the medication was not administered until 04/05/24 at 5:00 PM. Further record review did not reveal any documentation of why the medication was not administered when ordered. Further record review revealed an order dated 04/21/24 for Permethrin External Lotion 1% to apply to upper back topically every day and evening shift for Itching for 2 weeks. There was no documentation of the condition of Resident #97's rash since the initial order of the medication for itching on 03/30/24. An interview was conducted with the Director of Nursing (DON) on 04/24/24 at 11:00 AM. The DON stated she was not aware of Resident #97's rash and prescribed treatment. The DON acknowledged the prescribed treatment is used to treat scabies. The DON further acknowledged the lack of documentation of the resident's rash, and the resident did not have a dermatologist consult ordered. An interview was conducted with Staff G, Licensed Practical Nurse (LPN), on 04/24/24 at 11:20 PM. Staff G stated she was aware of the rash on Resident #97's back. Staff G stated she did not know if the rash itched, as the resident could not verbalize if it did. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with Resident #97's Power of Attorney (POA) at bedside on 04/25/24 at 11:00 AM. The POA stated she was aware of the rash on the resident's back and the facility had prescribed a cream for the rash. The POA stated she had inquired if the rash was scabies and was told no. The POA did not know if the resident was still receiving the cream. A phone interview was conducted with the Nurse Practitioner (NP) on 04/25/24 at 1:15 PM. The NP stated Resident #97 did not have Scabies. The NP stated she prescribed Permethrin for Resident #97 due to the fact the resident was in the hospital for 2 months, was now bedbound, and at high risk for infection. The medication is to prevent an infection. The surveyor questioned the NP about a dermatologist consult for the resident's rash. The NP replied, That's a good idea. A phone interview was conducted with the Consultant Pharmacist on 04/25/24 at 1:25 PM. The Consultant Pharmacist stated Permethrin is used to treat Scabies. The Consultant Pharmacist stated he was not aware of any off-label use for the medication. 39026 2. Record review documented Resident #59 was admitted to the facility on [DATE] with diagnoses that included Cerebral Infarction, Chronic Obstructive Pulmonary Disease and Type 2 Diabetes. Review of the annual Minimum Data Set (MDS) with an assessment reference date of 04/06/24 documented the Brief Interview for Mental Status (BIMS) score was 12, indicating the resident had mild cognitive impairment. On 04/23/24 at 10:21 AM, an interview was conducted with the resident. She stated she was having burning with urination. Upon leaving the room, Staff C, LPN was standing outside of the room. Staff C was asked if she was the nurse for this resident and she said that she was. The surveyor relayed to Staff C that the resident stated she had burning with urination and asked if she could go to check on her. Staff C stated she would follow up and speak with the resident. On 04/24/24 at 11:00 AM while doing a record review for Resident #59, there were no progress notes written about a conversation with the resident regarding burning with urination or any new orders. On 04/24/24 at 1:55 PM, the surveyor spoke with Staff C again and asked if she followed up with the resident since there are no progress notes to this effect. She stated she called the resident's primary doctor yesterday and he said no new orders. She stated that she did not write a progress note but will put one in the record today. Review of a 'general note', dated 04/24/24 at 2:00 PM, documented: nurse follow up with resident regarding resident stating that she has pain while urinating. Resident stated, I still have a little bit of pain while urinating. Nurse called MD and left a message, waiting for a call back. Care continues. Review of the progress note written by Staff C dated 04/24/24 at 2:50 PM revealed Nurse followed up with resident today, resident stated I still have a little bit of pain while urinating. Nurse called MD yesterday and received NNO [no new orders]. Nurse called MD [Medical Director] back today regarding resident still c/o [complaining of] pain while urinating, received new orders for U/A C&S [Urinalysis Culture & Sensitivity] to be collected. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/24/24 at 2:57 PM, the surveyor called the nurse who stated she takes care of the nursing home calls for the doctor. She stated the facility called an hour ago and got an order from the physician for a urine problem for that resident. She was asked if the facility had called yesterday for this resident, and she looked in her records and stated that there was no call yesterday. On 04/24/24 at 4:30 PM, a phone interview was conducted with the Physician, who stated there was no call yesterday to him regarding this resident. On 04/24/24 at 5:00 PM, the findings were discussed with the Regional Nurse Consultant. On 04/24/24 at 7:20 PM, the Director of Nurses received an order for Pyridium for Resident #59. Pyridium is a medication used to relieve symptoms caused by irritation of the urinary tract such as pain and burning. On 04/25/24 at 12:30 PM during interview the resident stated that she is not feeling the burning today. On 04/25/24 at 1:00 PM, the Regional Nurse Consultant revealed that a urine sample was obtained and was picked up this morning by the lab.

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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** 39026 Based on observation, interviews, record, and policy review; the facility failed to maintain physician oversight for worsening pressure wounds for 1 of 1 sampled resident reviewed for pressure wounds, Resident #64. The findings included: The facility's policy, titled, Pressure Injury Prevention and Management, implemented 11/2020 and revised 07/25/22, revealed The facility shall establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce, or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate. Record review revealed Resident #64 was admitted to the facility on [DATE] post hospitalization . The documented diagnoses included Cerebral Infarction, Type 2 Diabetes, and Dysphagia. The quarterly Minimum Data Set (MDS) with an assessment reference date of 02/21/24, documented the Brief Interview for Mental Status (BIMS) score was 01, indicating the resident had severe cognitive impairment. Review of the wound documentation included: On admission (11/17/20), the resident was evaluated with the Braden Scale for Predicting Pressure Sore Risk with a score of 13, indicating the resident had a mild risk of developing pressure sores. On 01/05/24, an event note was created in the electronic health record (EHR) that revealed open skin to sacrum area 4 cm (centimeter) length x 5 cm width x 1 cm depth. On 01/25/24, the wound to the sacrum measured 4 cm x 1.5 cm. On 02/01/24, the wound on the sacrum was unstageable and measured 3.5 cm x 2.5 cm x 0.1 cm. On 02/07/24, a 6.0 cm x 4.0 x 0.1 cm unstageable pressure wound was found on the right hip. On 02/10/24, a nursing progress note documented the skin on the right hip worsened and has become a Stage 2 pressure ulcer (partial thickness skin loss). On 02/15/24, the wound note revealed the sacrum had slough, (non-viable stringy tissue) and was worsening. It documented 25 % necrotic and measured 6 cm x 6 cm x 0 unstageable. On 02/21/24, the wound note revealed the right hip was necrotic and measured 5.5 cm x 4 cm x 0. The wound was worsening. The sacrum measured 6 cm x 7 cm x 0 cm and was 10% necrotic. The right hip had 100% necrotic tissue and measured 5.5 cm x 3.5cm x 0. On 02/29/24, the sacrum had granulation tissue present and measured 5 cm x 4.5 cm x 0. The right hip was necrotic and measured 6 cm x 6 cm x 0 with the wound worsening. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/06/24, the right hip was necrotic and measured 5 cm x 5 cm x 0. The sacrum had granulation and slough tissue and measured 5 cm x 5 cm x 0.5 cm. On 03/15/24, the sacrum was unstageable and measured 5 cm x 5 cm x 0 cm. The right hip had necrotic tissue present and measured 6 cm x 5.5 cm x 0 cm with purulent (contains pus) drainage. On 03/21/24, the sacrum measured 6 cm x 5 cm x 0 and unstageable. The right hip is unstageable at 6 cm x 4.5 cm x 0.2 cm with purulent drainage. On 03/21/24, a nursing progress note revealed the resident was noted with redness and scab to left hip. On 03/29/24, the resident was first seen by a wound care nurse practitioner. The Wound assessment of the right hip wound revealed a pressure wound stage 4 (full thickness skin and tissue loss). Size of 5.5 cm x 5 cm x 4.5 cm. Undermining from 11 o'clock to 7 o'clock, 4 cm. (the destruction of tissue or ulceration extending under the skin edges (margins) so that the pressure ulcer is larger at its base than at the skin surface.) Sacrum wound. pressure stage 3 (full thickness skin loss). Size 4.5 cm x 5 cm x 0.2 cm. Wound left hip. Pressure wound and unstageable measured 3 cm x 2 cm x 0.1 cm. On 040/5/24, the right hip measured 5 cm x 5 cm x 4.5 cm undermining from 11 o'clock to 7 o'clock, 4 cm. Surgical Wound Debridement done to the right hip. Sacrum wound measured 4.5 cm x 5 cm x 0.2 cm. The left hip wound is unstageable 3 cm x 1.5 cm x 0.1 cm. On 04/12/24, the right hip measured 5 cm x 5 cm x 4.5 cm with undermining from 11 o'clock to 7 o'clock, 4 cm. The sacrum measured 4 cm x 4 cm x 0.2 cm. The left hip measured 5 cm x 1.5 cm x 0.1 cm. On 04/19/24, the right hip measured 5 cm x 5 cm x 4.5 cm with undermining from 11 o'clock to 7 o'clock, 4 cm. The sacrum measured 3.5 cm x 4 cm x 0.2 cm. The left hip stable eschar 5 cm x 1.5 cm x 0.1 cm. Review of the Physician note dated 01/05/24 revealed the patient used to be on PO (by mouth) and PEG (Percutaneous Endoscopic Gastrostomy) feeds but got overweight, so PEG was d/c [discontinued]. Now weight loss, weight change -13 pounds. Her previous weight was 158 pounds, now she is 146 pounds. On 01/08/24, seen by the Nurse Practitioner (NP) with no note regarding a wound. On 01/10/24, Physician visit with no note regarding a wound. On 01/12/24, Physician visit with no wound note. On 01/24/24, Physician visit with no wound note. On 03/05/24, NP visit with no wound note. On 03/29/24, the resident had the PEG tube reinserted. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/02/24, NP visit note with no wound note. An interview was conducted with the son of Resident #64 on 04/24/24 at 1:28 PM. He had a concern that on Wednesday through Sunday when he feeds her, she doesn't always have protein with her meal, sometimes it is 2 starches. He said she is very fussy with meals and textures and doesn't always want to eat the food she is given. The Dietician encouraged putting back the PEG tube due to weight loss. The first time she had a PEG tube was due to a bowel resection. Interview with the Dietary Manager on 04/25/24 at 9:23 AM revealed she is aware that they always need puree chicken and beef available for this resident and she says she goes through the ticket daily. They realized there was a problem with meal tracker with the protein-and her dislikes and it was brought to her attention by one of the cooks that there was no protein on her plate. She stated this could have happened a few times. This was identified with the transition, and they started the new meal tracker in February 2024 and now they know they have to scan the tickets. Observation of wound care with Staff G, Licensed Practical Nurse / LPN, was conducted on 04/25/24 at 10:32 AM. The right hip was cleansed with wound cleanser / normal saline, patted dry and Collagen and Medi Honey was applied. The wound was covered with Bordered Foam. The sacrum was cleansed with wound cleanser / normal saline, patted dry and Medi-honey and Collagen were applied. The wound was covered with bordered gauze. The resident had slight discomfort while the wound was being cleaned. The wound care to left hip was not observed. On 04/25/24 at 12:15 PM, an interview was conducted with the Director of Nurses (DON) regarding wound care in the facility. She stated that prior to January 2024, they had a directive to stop the wound care physician from coming in and the nurse manager would do the weekly pressure wound checks. The wound care physician started coming to the facility again on 03/29/24 and comes weekly. An interview was conducted with the resident's physician via telephone on 04/25/24 at 1:50 PM. He stated that he cannot say that he visually saw the wounds on Resident #64, but he did say that if he saw them, he would have documented it in his notes. Interview was conducted with Staff H, Certified Nursing Assistant (CNA), on 04/25/24 at 2:03 PM. She stated every 2 hours she turns and repositions Resident #64. It takes 2 of them to do that. They had been putting her from bed to chair but after the wounds she stays mostly in bed. Interview was conducted with Staff D, CNA, on 04/25/24 at 2:08 PM. She stated that she is aware of the wounds, they go in, 2 of them, every 2 hours to turn her. Even before the wounds started, they would turn and reposition her. She mostly stays in bed now. Staff D stated before the wounds, she would get up. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview was conducted with Staff I, Registered Nurse (RN) / Unit Manager, on 04/25/24 at 2:12 PM. She stated the physician knew of the wounds and if there was a change she notified the physician. The physician was not with her during weekly wound rounds. She previously did wound rounds with the prior wound physician, so she was asked to do the wound rounds after the wound care physician was no longer coming. She stated it had been a while since he came. She stated that sometimes the wounds looked better and sometimes they looked worse. Orders were changed when the wounds looked worse. She stated the physician comes to the facility on Monday, Wednesday, and Friday. She stated that they spoke in general about the wounds, but he was not given the specific measurements of the wounds. An interview was conducted with the DON on 04/25/24 at 2:19 PM. She stated she kept the physician updated about the wounds and she would tell him the wounds were stable, or if they got worse, then she would call him to get orders. She stated she was happy when the wound care physician came because the wounds needed to be debrided.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40153 Based on observations, interviews, and record review, the facility failed to timely identify residents with malnutrition status and provide nutritional interventions, which resulted in weight loss and pressure ulcer development for 1 of 4 sampled residents, Resident #64, reviewed for tube feeding (GT). The findings included: Review of the Clinical Nutrition: the American Society for Parenteral and Enteral Nutrition (ASPEN) / Academy of Nutrition and Dietetics Consensus: Characteristics of Protein / Calorie Malnutrition, dated 07/2018, documented in part, the following two characteristics: severe calories and protein malnutrition is classified as eating less than 75% of estimated energy requirement for over one month, and 5% weight loss in one month. A minimum of 2 of the six characteristics (as shown above) is recommended for diagnosis of either severe or moderate protein-calorie malnutrition. (https://www.[NAME].com/searchq=aspen+malnutrition+assessment+pdf&FORM=QSRE1&ntref=1). Record review showed Resident #64 was initially admitted to the facility on [DATE] with diagnoses of Cerebral Infarction, Dysphagia, Muscle Weakness, and Type 2 Diabetes. Resident #64 had a Percutaneous Endoscopic Gastrostomy (PEG) tube, which was removed on 11/07/23 and reinserted on 03/29/24. Review of the Minimum Data Set (MDS) quarterly assessment, dated 02/21/24, revealed a Brief Interview of Mental Status (BIMS) score of 01, indicating severe cognitive impairment. Record review of the current physician order showed the following: On 04/22/24, Jevity 1.2 at 75 ml an hour for 12 hours once. On 04/19/24, House 2.0 nutritional supplements two times a day. On 04/05/14, Every shift administer Glucerna 1.5 (tube feeding formulary type) continuous at 75 ml an hour for 12 hours for a total volume of 900 ml and to start at 6:00 PM. On 12/27/23, Carbohydrate diet, pureed texture, thin consistency. Review of the weight log for Resident #64 revealed the following: On 01/05/24, a physician note documented the patient used to be on PO (by mouth) and PEG (Percutaneous Endoscopic Gastrostomy) feeds but got overweight, so PEG was d/c [discontinued]. Now weight loss, weight change -13 pounds. Her previous weight was 158 pounds, now she is 146 pounds. On 01/25/24, 147 pounds. On 02/14/24, 142 pounds. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/21/24, 140.6 pounds. On 02/28/24, 137 pounds. On 03/13/24, 133 pounds. On 04/11/24 , 132 pounds. On 04/19/24, 130 pounds. In an observation conducted on 04/23/24 at 4:17 PM, Resident #64 was in bed with the tube (Percutaneous Endoscopic Gastrostomy (PEG) tube) feeding bottle on hold with a formulary Jevity 1.2 at 75 milliliters (ml) an hour. The tube feeding had a start date of 04/22/24 with no start time. The tube feeding bottle was noted at the 250 ml mark out of the 1000 ml capacity bottle. The tube feeding, Jevity 1.2 at 75 ml an hour for 12 hours, provided 1080 calories and 50 grams of protein. In an observation conducted on 04/24/24 at 7:40 AM, the tube feeding bag noted formulary Glucerna 1.5 running at 75 ml an hour. Closer observation revealed the start date on the bottle was 04/23/24, but there was no start time. The tube feeding bag was noted at the 450 ml mark out of a 1000 ml capacity bottle. The tube feeding Glucerna 1.5 times 75 ml an hour for 12 hours provided 1350 calories and 75 grams of protein. In an interview conducted on 04/24/24 at 7:43 AM, Staff C, Licensed Practical Nurse (LPN), stated that Resident #64 tolerates her tube feeding well. She further said that the tube feeding bag was already started and running when she arrived for her shift this morning. In an interview conducted on 04/24/24 at 7:45 AM, Staff B, LPN, stated that when she arrived at her shift last night at 11:00 PM, the tube feeding bag was already started by the 3:00 PM to 11:00 PM shift nurse. According to Staff B, the tube feeding was still noted at the top level when she arrived for her shift (11 PM). In an observation conducted on 04/24/24 at 8:47 AM, Resident #64 was in the room with the tube feeding running at 75 ml an hour. Staff D, Certified Nursing Assistant (CNA), was noted at the bedside, sitting near Resident #64, feeding her the breakfast tray while the tube feeding was still running. In an observation conducted on 04/24/24 at 9:23 AM, Staff D was in the room still feeding Resident #64 her breakfast meal. The tube feeding was still running at the time of this observation and was noted at the 300 ml mark out of a 1000 ml capacity bottle. In an interview conducted on 04/24/24 at 12:30 PM, Resident #64's family stated that at times, the meal trays would not have any protein on the trays and only had servings of starches and vegetables. They further stated that they come to visit Resident #64 at least four times a week, that many times the meal trays were missing the nutritional supplements, and that they needed to call the kitchen to request the supplements. (continued on next page)

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	105679	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regents Park of Sunrise	9711 W Oakland Park Blvd Sunrise, FL 33351

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Physician's note dated 01/12/24 revealed Resident #64 used to eat by mouth with a PEG in place but got overweight, and the PEG was removed. No weight loss was noted, but Resident #64 was still with poor intake. The diet was modified to a mechanical soft diet with a dietitian consultation. Another Physician's note dated 01/24/24 revealed Resident #64's appetite was better, with diet modification and dietitian consultation in place. The next Physician' progress note was not until 03/05/24, 41 days later. Review of the Medication Administration Record (MAR) for the month of January 2024 showed that an order for 30 ml (milliliters) of Prostat (protein supplement) was added twice a day, which provided 200 calories and 30 grams of protein a day. Review of the Nutrition Risk Screen completed on 01/25/24 by the facility's Dietitian revealed the following: Resident #64 was on a pureed diet texture and receiving Mighty Shakes (nutritional supplements) twice a day with no proof of documentation provided showing that Resident #64 received the Mighty Shakes daily. On this note, Resident #64 ate between 0-75% of her meals, with estimated daily caloric needs between 1670 calories and 2000 calories and between 84 and 100 grams of protein. Review of Resident #64's weight log showed that from 02/05/24 to 03/06/24, the resident dropped from 145 pounds to 135 pounds in one month, a 6.9% weight loss. Review of the follow-up nutrition note dated 02/14/24 revealed Resident #64's weight was trending down, and a house 2.0 nutritional supplement was recommended, which provided an extra 240 calories and 10 grams of protein a day. A nutrition progress note dated 02/21/24 revealed Resident #64 had a severe weight loss of 11.1 % in 90 days. Intake of meals was noted between 0-75%, and Resident #64 was to be receiving a House 2.0 nutritional shake twice a day (no evidence it was provided twice daily) and was only receiving it once a day. Review of the Nutrition Risk Screen dated 02/28/24 revealed Resident #64's meal intake was between 26% and 50%, with weight trending down. It further revealed that Resident #64 received one house 2.0 supplement and 30 grams of protein daily. Estimated caloric needs were changed from 1910 calories to 2237 calories a day and 80 grams to 97 grams of protein a day. Resident #64 was on a diet by mouth, providing about 2000 calories and 100 grams of protein daily. The resident's 25% intake of meals with the nutritional supplements provided 940 calories a day and 65 grams of protein a day. The resident's 50% intake of meals with dietary supplements provided 1440 calories a day and 90 grams of protein a day. Review of the Nutrition Risk Screen completed on 03/07/24 showed that Resident #64 was still eating between 26% and 50% of her meals. A severe weight loss of 6.9% was noted, with pressure ulcer wounds noted to the sacrum and right hip areas. On this note, the facility's Dietitian recommended continuing the same nutritional supplements in place (Prostat twice a day and House 2.0 once a day). There were no other additional supplements were recommended or provided. The Dietitian recommended the insertion of the PEG in place, which was done on 03/29/24. Further review of the MAR revealed that the house 2.0 nutritional supplements were not documented as provided from 04/01/24 to 04/12/24. It further showed that an order for house 2.0 nutritional supplements increased to twice a day on 04/19/24, after poor intake of 0 to 50% of meals. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the nutrition progress note dated 03/13/24 revealed Resident #64's Body Mass Index (BMI) was at 21.5, which dropped from 23.7 on 01/25/24 to 21.5 on 03/13/24. The BMI range of 21.5 is within normal ranges (underweight range is 19 and below). On this note, the facility's Dietitian reported an intake of 0 to 50% of meals for Resident #64. Resident #64 was still receiving two scoops of Prostat (providing 200 calories and 30 grams of protein) and a house 2.0 nutritional supplement once a day, which was providing an extra 240 calories and 10 grams of protein. The facility's Dietitian did not recommend increasing the house 2. 0 to twice or three times a day to provide additional calories and protein to Resident #64. Review of another follow-up nutritional progress note dated 03/20/24 revealed that Resident #64 had a severe weight loss of 5.1% in one month and was still eating 0 to 50% of her meals. The resident was on a pureed texture diet and received two scoops of Prostat (200 calories and 30 grams of protein) and a house 2. 0 nutritional supplement once a day, providing an extra 240 calories and 10 grams of protein. On this progress note, the facility's Dietitian failed to identify or document Resident #64 at moderate to severe malnutrition status as per ASPEN guidelines above. The facility's Dietitian failed to recommend an additional nutritional supplement that could have been given by nursing with the percent intake documented to aid with the 0-50% intake of meals. Review of the Nutrition Risk Screen dated 04/05/24 showed the following: Resident #64 was receiving tube feeding with Glucerna 1.5 at 65 ml an hour, which provided 1170 calories and 64 grams of protein, and was eating by mouth with 0 to 50% intake of meals. On this note, the facility's Dietitian recommended increasing the rate to 75 ml an hour for 12 hours because Resident #64 had inadequate oral intake with increased protein needs related to pressure injuries. The tube feeding Glucerna 1.5 at 75 ml an hour provides 1350 calories and 75 grams of protein. The Dietitian also recommended decreasing the protein supplements from twice a day to once a day, providing 15 grams extra protein a day instead of 30 grams of protein a day. Review of the Certified Nursing Assistant tasks for intake of meals showed the following percentages for Resident #64: from 03/25/24 to 04/23/24, 86 meals were consumed between 26% to 31% for a total of 86 meals documented. Review of the Weekly Pressure Wound Evaluation dated 02/08/24 and 03/15/24 showed a right hip pressure wound was acquired on 02/07/24. Review of the Weekly Pressure Wound Evaluation dated 02/21/24 and 03/21/24 showed a sacrum pressure wound was acquired on 02/05/24. Review of the nutrition progress note dated 04/23/24 revealed Resident #64 had a stage 3 pressure ulcer on the sacrum area and a stage 4 pressure ulcer on the right hip. Review of Resident #64's primary Physician's follow up assessments did not show that the nutritional status of Resident #64, the development of pressure ulcers, weight loss, and poor appetite were addressed. Further review did not show that an appetite stimulant was recommended or ordered for Resident #64. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the care plan initiated on 04/01/24 revealed Resident #64 received enteral feeding to supplement dietary intake. It showed tube feeding was administered as ordered to obtain adequate nutrition and hydration. A nutritional care plan revised on 04/08/24 showed that Resident #64 will have no signs and symptoms of malnutrition and will consume at least 25% of at least three meals daily. In an interview conducted on 04/24/24 at 12:53 PM with the facility's Dietitian, she stated that she placed an order for Jevity 1.2 (one day only 04/22/24) instead of Glucerna 1.5 for Resident #64 because they were out of the Glucerna 1.5 but did not adjust the tube feeding rate and hours, for the change in the tube feeding formulary. She acknowledged that Resident #64 had a severe weight loss of 6.9% from 02/05/24 to 03/06/24. When asked why she did not increase the House 2.0 nutritional supplement daily, she said she provided Resident #64 with a Mighty Shake supplement on the meal trays. She could not show documentation that the Mighty Shakes were provided on the meal trays or ordered on the MAR According to the facility's Dietitian, the Mighty Shakes are provided on the trays, but the percent intake of these nutritional supplements was not documented. She stated this is why she went ahead and increased the house shake to 2.0 twice a day, which was on 04/19/24. These would have provided higher calories and ensured that they were given by nursing staff with the percentage of intake documented, which was better than the mighty shakes on the meal trays. When asked why she did not provide additional nutritional supplements until 04/19/24, she did not have an answer. The clinical Dietitian acknowledged that Jevity 1.2 at 75 ml an hour did not provide the same calories and protein as the Glucerna 1.5 at 75 ml an hour. She further said that she discussed restarting the tube feeding with Resident #64's family around March of 2024 and it was placed later on 03/29/24. She was then asked why Resident #64 did not have protein food items on her meal trays. The facility's Dietitian stated that Resident #64 had over 86 dislikes on her food preference list and that she only eats meat and chicken, which may not have been on the menu that day. The surveyor expressed concerns regarding the nutritional interventions that were not implemented in a timely manner from January 2024 to April 2024. An interview was conducted on 04/24/24 at 2:00 PM with the facility's Dietitian who stated that the tube feeding needs to be on hold during meal times for Resident #64 to eat her meals.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39026 Based on observation, interviews, policy and record review, the facility failed to limit a new order for a psychotropic drug used on a PRN (as needed) basis for 1 of 5 sampled residents reviewed for unnecessary medication review, Resident #156. The findings included: The facility's policy, titled, Unnecessary Drugs-Without Adequate Indication for Use, implemented 11/2020 and revised 08/02/22, revealed in part, A new order for a psychotropic or antipsychotic medications used on a PRN basis should follow the requirements for PRN use of psychotropic or antipsychotic medications. Record review documented Resident #156 was admitted to the facility on [DATE], post hospitalization with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD), Syncope, Diabetes Type 2, and Anxiety Disorder. Review of the admission Minimum Data Set (MDS) with an assessment reference date of 04/08/24 documented the Brief Interview for Mental Status (BIMS) score was 15 indicating the resident was cognitively intact. On 04/04/24, the physician documented an order for Alprazolam Oral Tablet 2 MG (milligrams) Give 1 tablet by mouth as needed for sleep at bedtime. On 04/24/24 at 10:07 AM, pharmacy recommendations were discussed with the consultant pharmacist. The consultant pharmacist revealed that he reviewed the medications for Resident #156 on 04/10/24 and recommended to either discontinue or add a stop date to the PRN Alprazolam, or update to schedule dosing. The physician disagreed with the recommendation on 04/12/24 but gave no rational in the medical record or no indication for the duration for the PRN order. The finding was reviewed and discussed with the Regional Nurse Consultant on 04/24/24 at 5:00 PM who stated she was aware of the recommendation and the order had just been changed to Alprazolam 1 milligram, give 1 tablet by mouth at bedtime for Anxiety.