STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105709	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nspire Healthcare Miami Lakes	5725 NW 186 Street Hialeah, FL 33015

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48906 Based on observations, record review and interviews facility failed to provide dignity for one resident (#87) out twelve residents who are assisted with meals as evidenced by an observation of staff standing while assisting Resident#87 with a meal. There were 119 residents residing in the facility at the time of survey. The Findings Included: On 8/26/24 at 8:35 AM Resident#87 was seated in the upright position in bed. Staff H, Registered Nurse (RN) was standing while assisting Resident#87 with breakfast. On 8/26/24 08:40 AM Staff H, RN stated, It is the protocol of this facility to set up the resident in the upright position and be at eye level for meals. I'm not sure if I can stand while assisting residents with meals. Also stated I have not received any in-services regarding this. Lastly stated I started in July of 2023. Record review of demographic sheet for Resident#87 revealed an admitted [DATE] with diagnosis that included Dementia. Record review of Quarterly Minimum Data Set (MDS) with reference date of 7/24/24 Section C (Cognitive Status) revealed a Brief Interview of Mental Status (BIMS) score of 3 indicated severe cognitive impairment, section GG (functional status) revealed set up clean up assistance for eating, and section K (Swallowing) revealed no or unknown significant weight gain/ loss in last month or 6 months and Resident#87 was receiving a therapeutic diet. Record review of physician orders sheet revealed an order dated 1/17/24 directions: No added salt diet and regular texture. Record review of Care Plan initiated on 1/17/24 and started on 5/24/24 revealed Resident#87 had potential nutritional problem related to fair appetite and intake at meals, receiving therapeutic diet with the goal of will experience no significant weight change through review date. The interventions included provide, serve diet as ordered. Monitor intake and record each meal. On 8/29/24 at 2:05 PM The Director of Nursing (DON) stated, Staff are to be seated next to the resident while assisting them to eat and staff are aware of this protocol. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105709	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of The Policies and Procedures Subject: Feeding Residents requiring Assistance Effective Date: 11/30/2018 Revision Date: 9/19/23 Policy: Nursing personnel will provide assistance with feeding when a resident is unable to do do independently. Procedure: Position resident comfortably, transfer to straight back chair if appropriate.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48906 Based on observations, record review and interview facility failed to accurately code a Minimum Data Set (MDS) for one resident (Resident #34) out of nine sampled residents, as evidenced by hearing aids not included in Section B of the Medicare 5-day MDS with reference date of 7/8/24 despite Resident #34 using hearing aids on a daily basis. The findings included: On 8/26/24 at 9:05 AM Resident #34 signaled to surveyor her inability to hear and to come closer. Hearing aids observed on nightstand. On 8/28/24 at 1:20 PM Resident #34 was seated in a wheelchair near bed. Hearing aids in place. Family at bedside. Record review of demographic sheet for Resident #34 revealed an admitted [DATE] with Diagnosis that included: Dementia. Record review of a Medicare 5-day Minimum Data Set (MDS) with reference date of 7/8/24 for Resident#34 Section B revealed Hearing- Adequate, Hearing Aid- No, Ability to Understand others: understands. Record review of a Care Plan initiated on 6/10/24 revealed Resident #34 had an Activities of Daily Living (ADL) self-care performance deficit related to hearing difficulty with a goal of will improve current level of function in ADLs through next review. The interventions included: Encourage resident to participate in fullest extent possible with each interaction. Record review of a physician's order sheet revealed an order dated 6/11/24 for diagnosis: Hearing Difficulty. On 8/29/24 at 9:15 AM The Social Services Director reported ; the Medicare 5-day MDS dated [DATE] Section B for Resident #34 is incorrectly coded and Section B should have be coded to included hearing aids. Record review of Policies and Procedures: Subject: MDS Effective Date: 11/30/2014 Revision Date: 9/25/2017 Policy: The center conducts initial and periodic standardized, comprehensive and reproducible assessments no less than every three months for each resident including, but not limited to, the collection of data regarding functional status, strengths, weaknesses, and preferences using the federal and/or state required RAI. Procedure: Specified sections of the RAI process are completed by the center designated Interdisciplinary Team Members. Each person completing a section or portion of a section of the MDS signs the Attestation Statement indicating its accuracy.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48906 Based on observations, interview and record review facility failed to implement care plans for two residents (Resident #302 and Resident #252) out of nine sampled as evidenced by splinting device not applied for Resident#302 and no skin treatment done for Resident#252. The findings included: 1) On 8/26/24 at 10:08 AM Resident #302 was observed seated in the upright position in bed. Resident #302's left arm appeared weak and left hand appeared contracted. A splinting device was observed on a wheelchair next to Resident #302's bed. On 8/28/24 at 1:29 PM Resident #302 was seated in a wheelchair next to bed. A splinting device observed in a plastic bag on nightstand. Record review of demographic sheet for Resident #302 revealed an admitted [DATE] with diagnosis that included: Muscle Weakness. Record review of physician orders sheet revealed an order dated 8/23/24 directions: Left resting hand splint for positioning and electrical stimulation application to left upper extremity (LUE) to facilitate volitional movements. Record review of Electronic Health record for Resident #302 revealed an Admission Minimum Data Set (MDS) with reference date of 8/29/24 was in progress. Record review of a Care Plan for Resident #302 initiated on 8/29/24 revealed Risk for pain and discomfort related to Cerebrovascular Accident, Left side Hemiplegia, use left hand resting splint with a goal of will not have an interruption in normal activities due to pain through review date. The interventions included: Use resting left hand splint for position and Neuromuscular electrical stimulation (NMES) application to LUE to facilitate volitional movements. On 8/28/24 at 12:50 PM Staff E, Certified Nursing Assistant (CNA) stated, Every morning after hygiene care I offer to apply the splinting device for [Resident #302] and [Resident #302] allows me to do it. Today was the first day [Resident #302] refused for me to apply the splint and wanted therapy to do it. When [Resident #302] refuses I inform nurse. Today I haven't let the nurse yet. I did not notice it was removed Tuesday or Monday. On 08/28/24 at 1:15 PM The Occupational Therapist stated, I wrote the order for a splinting device to prevent contracture of the left hand of [Resident#302]. It should be applied when she is sitting upright. Therapy is responsible for applying the splint daily. There is no time frame because it is for a trial basis. When asked how staff know when to apply or when to remove there was no answer. On 08/28/24 at 1:23 PM Staff C, Registered Nurse (RN) stated: I was not aware that [Resident #302] was removing her splinting device. I am not clear on the frequency of applying the splint. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/28/24 at 1:25 PM Staff F, Occupational Therapy Assistant stated, There is no specific time frame for the splinting device. It is a trail to determine if Resident#302 will have movement. I will apply the splint during therapy. On 8/29/24 at 8:28 AM Resident #302 stated, Sometimes the splint hurts my neck because my arm is heavy. I do not have any issue with allowing staff to apply the device. I do not refuse for staff to apply the splint. On 8/29/24 at 9:31 AM The Director of Nursing stated, When a resident is admitted from the hospital with others for splinting devices we follow the orders. If therapy wants to implement splinting devices for a trail there is no schedule. When it is a trial basis therapy is responsible to apply the device. Therapy is responsible to communicate with nursing during the clinical meetings that are held every day about interventions needed for the residents. Record review of Progress notes for Resident #302 revealed no documentation about Resident #302 refusing the application of splinting device or removing device after it was applied. Record review of Policy Subject: Plans of Care Effective Date: 11/30/2014 Revision Date: 9/25/2017 Policy: An individualized person-centered plan of care will be established by the Interdisciplinary team (IDT) with the resident and /or resident representative(s) to the extent practicable and uploaded in accordance with state and federal regulatory requirements. plan of care is to be maintained as part of the final medical record. Procedure: Develop and implement an individualized Person-Centered Comprehensive plan of care by the Interdisciplinary team that includes but is not limited to- the attending physician, a registered nurse with responsibility for the resident, a nurse aide with responsibility for the resident, a member of food and nutrition services staff, and other appropriate staff or professionals in disciplines determined by the residents' needs or as requested by the resident, and , to the extent practicable, the participation of the resident and the resident's representative(s) within seven (7) days after the completion of the comprehensive assessment (MDS). 45019 2) Review of Resident #252 Care Plans Reference Dates 4/25/24 and 6/21/24 documented: The resident has potential/actual impairment to skin integrity related to fragile skin. Focus-the resident will maintain or develop clean and intact skin by the next review date. Interventions-encourage good nutrition and hydration to promote healthy skin, keep skin clean and dry, use lotion on dry skin, skin treatment to left ankle as ordered. Review of Resident #252's wound care note dated 06/14/2024 documented skin tear left ankle, Primary dressing-Mupirocin ointment, Secondary dressing: dry protective dressing, Dressing frequency: daily Review of Resident #252's weekly skin assessment note documented 6/14/24-left ankle (outer)-skin tear, treatment in place. Review of Resident #252 Treatment Administration Record (TAR) revealed there was no documentation for treatment to the resident's left ankle skin tear starting 06/14/2, treatment for the resident's left ankle skin tear started 06/21/24. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical records for Resident #252 revealed the resident was admitted to the facility on [DATE]. Clinical diagnoses included but not limited to: Seizures, Dementia, Gastrostomy status, Dysphagia, Altered mental status, Adult failure to thrive, Presence of Cardiac Implants and Grafts and Hemiplegia and Hemiparesis. Resident # was discharged on [DATE] to the hospital. Review of the Physician's Orders Sheet for May-June 2024 revealed Resident #252 had orders that included but not limited to: 6/21/24-Mupirocin external ointment 2% -apply to left ankle topically every day shift for wound care, clean left ankle with normal saline, pat dry, apply Mupirocin and cover with dry dressing daily. Record review of Resident #252 's Discharge Return anticipated Minimum Data Set (MDS) dated [DATE] revealed: Section C for Cognitive Patterns documented Brief Interview for Mental Status Score 2, on a 0-15 scale indicating the resident is cognitively impaired. Section GG for Functional Status documented the resident required maximal assistance for Activities of Daily living. Section M for Skin Conditions documented no pressure ulcers or deep tissue injuries. Interview on 08/29/24 at 12:47 the PM Director of Nursing (DON) stated the resident did not have a foot fungus, the skin tear to the left ankle was discovered on 06/20/24. On 06/20/24 treatment to the left ankle skin tear was started with Mupirocin ointment daily, Surveyor and DON viewed the skin assessment sheet dated 06/14/24, the weekly skin assessment stated the resident had a skin tear to the left ankle and treatment was in place, the DON stated the treatment administration record does not have any orders for treatment for a skin tear starting on 6/14/24, treatment for the resident's skin tear started on 06/20/24. The DON acknowledged there was a wound care order prescribed by the resident's physician on 06/14/24 for treatment for the left ankle skin tear for the resident that was not implemented. Interview on 08/29/24 at 01:34 PM Registered Nurse Wound Care (Staff B) stated: I have been doing wound care here at the facility for almost two (2) years, I started seeing this resident on 6/20/24 for treatment to the skin tear on her left ankle, prior to 06/20/24 the floor nurses treated the resident's skin. I am not aware if there was a prior order for treatment for the skin tear to the left ankle. The orders for treatment are prescribed by the resident's physician.

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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** 39177 Based on observations, record review and interview the facility failed to implement precautions to prevent catheter related injuries for two residents (Resident # 352 and Resident # 21) out of the three residents with indwelling catheters residing in the facility. As evidenced by Resident # 352 and Resident #21 indwelling catheter tubing were each observed touching the floor; and failed to ensure one out of one resident (Resident #252) with a prescribed order for skin tear treatment was implemented timely. Resident # 352 On 08/28/24 at 9:37 AM Resident #352 was observed seated in her wheelchair propelling along the hallway outside he room, the indwelling urinary catheter tubing was on touching the floor self-propelling wheelchair. (Photo evidence) Review of Resident #352's Admission Record indicated an admitted d 08/08/2024. Clinical Diagnoses include but not limited to: Acute kidney failure, Retention of urine, Hydronephrosis with urethral stricture not elsewhere classified. Review of Resident #352's admission orders indicated monitor indwelling catheters per shift; Leg strap anchor to indwelling catheter in place q (every) shift may change indwelling catheter monthly and as needed for blockage or leakage. Review of Resident # 352's Care Plan Initiated 8/9/2024 documented the resident has indwelling catheter with [catheter size] balloon, for urinary retention . the resident will remain free from catheter related trauma through review date. Leg strap to anchor indwelling catheter. Check tubing for kinks each shift. Review of the Initial Assessment Minimum Data Set (MDS) dated [DATE] revealed Resident #352 coded for indwelling catheter use. On 08/28/24 at 9: 42 AM Resident #352 stated; I am doing much better, they changed my [catheter brand] yesterday and I am going home tomorrow. The catheter bag was noted dated 08/2/24. On 08/29/24 at 10:15 AM Staff I Registered Nurse (RN) revealed the resident has an indwelling urinary catheter due to urinary retention. The resident will be discharged tomorrow to home, she was in the facility for therapy. Staff I, RN was shown the photograph with Resident # 352 seated in the wheelchair and the catheter tubing on the floor; Staff I acknowledged the concern and stated: That it is an infection control problem. It was changed yesterday. But I am going to change it During a follow up observation with staff I, in the resident's restroom the nurse acknowledged the date on the catheter was 08/27/24 not 08/28/24; Staff I, RN reported she made a mistake. 51356 Resident #21 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/26/24 at 09:01 AM Resident #21 was observed sitting in her wheelchair at the left side of her bed. The indwelling catheter tubing was observed on the floor.(Photo evidence) On 08/28/24 at 12:00 PM Resident #21 was observed sitting in her wheelchair on the right side of her bed eating lunch. The indwelling catheter tubing was observed on the floor. Record review of the resident's admission records revealed, Resident # 21 was initially admitted to the facility on [DATE] and readmitted on [DATE]. The resident's clinical diagnoses include but not limited to: Retention of urine, unspecified, Acute Kidney failure and Diabetes Mellitus. Review of the orders for August 2024 include order dated 8/11/24 - Cranberry Oral Tablet (Cranberry (Vaccinium macrocarpon)) Give 1 tablet by mouth one time a day for UTI (urinary tract infection), order dated 8/26/24 - May change indwelling catheter monthly and as needed for blockage or leakage as needed and every day shift starting on the 25th and ending on the 25th every month, order dated 8/23/24 - Enhanced barrier precautions due to [] indwelling catheter every shift, order dated 8/6/24 - Maintain [] catheter with [size] on balloon for Urinary Retention and change PRN (as needed) for obstruction, order dated 8/13/24 F/U follow up) with Urology (catheter (dx) diagnosis: urinary retention) Review of the Admission Minimum Data Set (MDS) Modification of admitted d 8/16/24, indicated in Section C for Cognitive Patterns, BIMS (Brief Interview of Mental Status) documented a score of 13 out 15 indicating the resident is gave an intact cognitive response. Section GG - Functional Abilities: Functional Limitation in Range of Motion: upper and lower extremities - No impairment. Mobility Devices: Wheelchair? - Yes; Self Care: Eating - supervision or touching assistance. H - Bladder and Bowel: Indwelling catheter? - Yes Review of the Resident # 21 Care Plans revealed an initiated date of 8/14/2024 and revision dated 8/26/2024 indicated- Focus: This resident has a Urinary Tract infection related to (r/t) abnormal urinalysis Culture and Sensitivity. Goals: The residents urinary tract infection will resolve without complications by the review date. Interventions: encourage adequate fluid intake, enhance barrier precaution r/t intravenous Antibiotics. Give antibiotic therapy as ordered. Monitor/document for side effects and effectiveness. Focus: This resident has Indwelling Catheter with [size] for Urinary Retention Goals: The resident will be/remain free from catheter-related trauma through review date. Intervention: Position catheter bag and tubing below the level of the bladder and away from entrance room door, enhance barrier precaution r/t catheter. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 8/28/24 at 12:36 PM Staff C, RN (Registered Nurse) revealed the catheter should not be touching the floor. She reported the resident transfers herself from bed to chair. I do rounds to check and to make sure the indwelling tubing is in the correct position. I also educate the resident about infection control. On 08/28/24 at 02:43 PM, Staff D, Certified Nursing Assistant stated: I assist the resident transferring from bed to chair and from chair to bed. This resident does not transfer alone. 45019 Resident #252 Review of Resident #252's wound care note dated 06/14/2024 documented skin tear left ankle, Primary dressing-Mupirocin ointment, Secondary dressing: dry protective dressing, Dressing frequency: daily Review of Resident #252's weekly skin assessment note documented 6/14/24-left ankle (outer)-skin tear, treatment in place. Review of Resident #252 Treatment Administration Record (TAR) revealed there was no documentation for treatment to the resident's left ankle skin tear starting 06/14/2, treatment for the resident's left ankle skin tear started 06/21/24. Review of the medical records for Resident #252 revealed the resident was admitted to the facility on [DATE]. Clinical diagnoses included but not limited to: Seizures, Dementia, Gastrostomy status and Altered mental status. Resident # was discharged on [DATE] to the hospital. Review of the Physician's Orders Sheet for May-June 2024 revealed Resident #252 had orders that included but not limited to: 6/21/24-Mupirocin external ointment 2% -apply to left ankle topically every day shift for wound care, clean left ankle with normal saline, pat dry, apply Mupirocin and cover with dry dressing daily. Record review of Resident #252 's Discharge Return anticipated Minimum Data Set (MDS) dated [DATE] revealed: Section C for Cognitive Patterns documented Brief Interview for Mental Status Score 2, on a 0-15 scale indicating the resident is cognitively impaired. Section GG for Functional Status documented the resident required maximal assistance for Activities of Daily living. Section M for Skin Conditions documented no pressure ulcers or deep tissue injuries. Review of Resident #252 Care Plans Reference Dates 4/25/24 and 6/21/24 documented: The resident has potential/actual impairment to skin integrity related to fragile skin. Focus-the resident will maintain or develop clean and intact skin by the next review date. Interventions-encourage good nutrition and hydration to promote healthy skin, keep skin clean and dry, use lotion on dry skin, skin treatment to left ankle as ordered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/29/24 at 12:47 PM the Director of Nursing (DON) stated the resident did not have a foot fungus, the skin tear to the left ankle was discovered on 06/20/24. On 06/20/24 treatment to the left ankle skin tear was started with Mupirocin ointment daily, Surveyor and the DON viewed the skin assessment sheet dated 06/14/24, the weekly skin assessment indicated the resident had a skin tear to the left ankle and treatment was in place, DON stated the treatment administration record does not have any orders for treatment for a skin tear starting on 6/14/24, treatment for the resident's skin tear started on 06/20/24. The DON acknowledged there was a wound care order prescribed by the resident's physician on 06/14/24 for treatment for the left ankle skin tear for the resident that was not implemented. Interview on 08/29/24 at 01:34 PM the Registered Nurse Wound Care (Staff B) stated: I have been doing wound care here at the facility for almost two (2) years, I started seeing this resident on 6/20/24 for treatment to the skin tear on her left ankle, prior to 06/20/24 the floor nurses treated the resident's skin. I am not aware if there was a prior order for treatment for the skin tear to the left ankle. The orders for treatment are prescribed by the resident's physician. Review of the facility policy and procedure titled Clinical Guideline Skin and Wound dated 04/01/2017 states: To provide a system for identifying skin at risk, implementing individual interventions including evaluation and monitoring as indicated to promote skin health, healing and decrease worsening of/prevention of pressure injury. Process: License nurse to complete skin evaluation weekly and prior to transfer/discharge and document in the medical record. License nurses to document the presence of skin impairment/new skin impairment when observed and weekly until resolved.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 31581 Based on observations, record review and interview the facility failed to ensure food was prepared under sanitary conditions as evidenced by failure to 1) maintain equipment in the kitchen in a clean sanitary manner, 2) the Unit 2 Pantry Freezer did not contain a thermometer and 3) the Unit 1 Pantry microwave in a clean sanitary manner. This has the potential to affect one hundred and fourteen out of one hundred and fifteen residents who eat orally residing in the facility at the time of the survey. The findings include: Record review of the facility's policy titled Nourishment Storage-Pantry (effective date 12/2023) documented: Policy-Resident Nourishments are stored properly to maintain food safety; Procedure-1) An accurate thermometer is maintained inside of the refrigerator and freezer. 1) Observation of the initial kitchen tour on 8/26/24 at 7:59 AM with the Certified Dietary Manager, Senior Food Service Director revealed brown like stains on the inside and outside of the convection oven doors. Photographic evidence submitted. On 8/26/24 at 8:00 AM, interview with the Certified Dietary Manager, Senior Food Service Director. He stated, We do a weekly clean of the oven. He confirmed the brown like stains on the inside and outside of the convection oven doors. 2) Observation of the Unit 2 Pantry Refrigerator on 8/27/24 at 11:35 AM revealed resident's food items were in the freezer with the resident's name, resident's room number and date that the food item was placed in the freezer. No thermometer was noted in the freezer. Observation and interview of the Unit 2 Pantry Refrigerator and Freezer with the Director of Nursing (DON) on 8/27/24 at 11:36 AM. She confirmed that the thermometer was not in the freezer. She called the Certified Dietary Manager, Senior Food Service Director on the cell phone to place one there. 3) Observation of the Unit 1 Pantry Refrigerator on 8/27/24 at 11:38 AM revealed the microwave used to warm up resident's foods was not clean, had brown, dried substances and contained brown-like rust stains in the microwave. Photographic evidence submitted. Observation and interview of the Unit 1 Pantry Microwave with the DON on 8/27/24 at 11:40 AM. She confirmed brown, dried substances and brown-like rust stains were in the microwave.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105709	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nspire Healthcare Miami Lakes	5725 NW 186 Street Hialeah, FL 33015

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 0867

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.

45019

Based on observations, interview and record review, the facility's quality assurance and assessment committee failed to demonstrate an effective plan of action was implemented to correct identified quality deficiency in the problem areas related to repeated deficient practice for F641 Accuracy of Assessments. The facility was cited for F641 in 2023. This repeated deficient practice has the potential to affect any of the 115 residents residing in the facility at the time of the survey.

The findings included:

Review of the facility policy and procedure titled Quality Assurance Performance Improvement Program (QAPI) revision date 10/24/22 states: The center and organization have a comprehensive, data driven Quality Assurance Performance Improvement Program that focuses on indicators of the outcomes of care and quality of life.

Procedures:

Identifying quality deficiencies and Corrective Action:

The center will review department system data.

If a quality deficiency is identified, the committee will oversee the development of corrective actions

The center may choose the method of corrective action i.e. Plan, Do, Study, Act or Performance Improvement Project.

Review of the Quality Assurance and Performance Improvement (QAPI) Committee Meeting Sign-in Sheets dated 06/2024,07/2024, and 08/2024 documented the facility had a QAA Committee meetings monthly. Attendees included: Administrator, Medical Director, Director of Nursing (DON), Assistant Director of Nursing (ADON), Infection Control Preventionist/Risk Manager, Dietary Manager, Clinical Dietician, Director of Housekeeping, Director of Maintenance, Director of therapy, Director of Human resources, Director of admissions, Director of Business office, Director of Social Services, Director of Activities, MDS (Minimum Data Set) Coordinator, and Discharge Planner.

Interview on 08/29/24 at2:20 PM with the Administrator/QA, Stated, the QAA Committee meets every month on the last Thursday of the month, the last meeting was held in the month of 08//2024. The committee consists of the Medical Director, Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), Infection Preventionist and all interdisciplinary team members. The purpose of QAPI is to identify any potential issues or any concerns where we will need additional education to be provided to the staff. QAPI is an ongoing program, a working tool, where multiple members get together to come up with solutions for problems and issues. We review previous agendas, see what is completed, what needs to be continued, what is resolved and address any new identified issues. We have Clinical meetings daily at 9am in the morning, we review issues from the prior day, we involve family of residents in planning of care and have the patient present if they are alert and oriented.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105709	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nspire Healthcare Miami Lakes	5725 NW 186 Street Hialeah, FL 33015

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 31581 Based on observation, interview and record review, the facility failed to ensure a 1) convection oven, food steamer and gas range stove used to prepare food for residents were in good repair and clean and 2) the Unit 1 Pantry microwave was clean. This has the potential to affect one hundred and fourteen out of one hundred and fifteen residents who eat orally residing in the facility at the time of the survey. The findings included: Record review of the facility's policy titled Maintenance (effective date 11/2014) documented: Policy-The facility's physical plant and equipment will be maintained through a program of preventive maintenance and prompt action to identify areas/items in need of repair; Procedure-The Director of Environmental Services will follow all policies regarding routine periodic maintenance and all employees will report physical plant areas or equipment in need of repair or service to their supervisor. 1) Observation of the initial kitchen tour on 8/26/24 at 7:59 AM with the Certified Dietary Manager, Senior Food Service Director revealed brown like stains on the inside and outside of the convection oven doors. Photographic evidence submitted. On 8/26/24 at 8:00 AM, interview with the Certified Dietary Manager, Senior Food Service Director. He stated, We do a weekly clean of the oven. He confirmed the brown like stains on the inside and outside of the convection oven doors. Observation of the initial kitchen tour with the Certified Dietary Manager, Senior Food Service Director on 8/26/24 at 8:02 AM revealed the food steamer was not working. Interview with Staff A, [NAME] on 8/26/24 at 8:03 AM. She stated, The steamer does not work and it keeps shutting off. Observation of the initial kitchen tour with the Certified Dietary Manager, Senior Food Service Director on 8/26/24 at 8:05 AM revealed only one side of the gas range stove was working. Interview with the Staff A, [NAME] on 8/26/24 at 8:06 AM. She stated, Only one side of the range is working. 2) Observation of the Unit 1 Pantry Refrigerator on 8/27/24 at 11:38 AM revealed the microwave used to warm up resident's foods was not clean, had brown, dried substances and contained brown-like rust stains in the microwave. Photographic evidence submitted. Observation and interview of the Unit 1 Pantry Microwave with the DON on 8/27/24 at 11:40 AM. She confirmed brown, dried substances and brown-like rust stains were in the microwave.