| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105719 | A. Building<br>B. Wing | 10/03/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Palace at Kendall Nursing and Rehabilitation Cente | 11215 SW 84th Street<br>Miami, FL 33173 |

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 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48906<br><br>Based on observation, record review and interviews, the facility failed to update a side rails care plan for one resident with a seizure disorder (#109) out of 18 residents with padded assist rails as evidenced by a physician's order for Resident #109 with directions to keep both side rails in the up position and a care plan with interventions that included side rails to be in the down position. There were 171 residents residing in the facility at the time of survey.<br><br>The findings included:<br><br>On 9/30/24 at 10:25 AM Resident #109 was observed in bed with eyes open, holding a toy. Two quarter length side rails observed in the up position. The right-side rail had a blue padding attached and the left side rail had no padding. A padding was noted on the recliner near the resident.<br><br>Record review of a demographic sheet for Resident #109 revealed an admitted [DATE] with diagnosis that included but not limited to: seizures, psychotic disturbance, anxiety disorder restlessness and agitation.<br><br>Record review of a Significant Change in Status Minimum Data Set (MDS) with a reference date of 9/5/24 Section C (Cognitive Status) revealed a Brief Interview for Mental was undetermined and Section GG (functional status) revealed Resident#109 was dependent on staff for all Activities of Daily Living.<br><br>Record review of a May 2024 physicians order sheet revealed an order for two assist rails up (in place) due to (Seizure precautions with padding) every shift every day.<br><br>Record review of a Potential for injury due to seizure disorder care plan initiated on 9/12/2024 with a goal to not sustain any injury related to seizure disorder thru next review date revealed interventions that included: two assist side rails down, horizontal, with padding to rails as prescribed.<br><br>On 10/03/24 at 1:33 PM; Staff D, Registered Nurse (RN) was asked to explain why the interventions for the side rails in the care plan differ from the orders,; Staff D stated: The nurses will follow the physician's order. We create the care plan according to the physician's order. The interventions are always resident specific.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 10/03/24 at 2:39 PM, the Director of Nursing (DON) was informed by surveyor about the difference in the care plan interventions for Resident #109's side rails and the physician's order. The DON replied, The reason the interventions do not match the order is because The MDS nurse used the old template for the seizure disorder care plan and the new template should have been used. There is a positioning device log that is used by staff and updated each morning to show all the residents with side rails and how they should be positioned.<br><br>Record review of a Policy entitled, Care Planning effective date: 7/12 last revision date: January 7, 2017, last reviewed date: January 24, 2014. Policy: The facility develops and implements a plan of care for each resident to ensure they receive personalized, high-quality care that meets their individualized needs and preferences, while promoting dignity, independence, and quality of life. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48906<br><br>Based on observations, interviews and record review the facility failed to ensure one resident (Resident #137) out of two sampled residents receive quality of care and treatment in accordance with professional standards as evidenced by observations of an undated dressing on the left side of Resident #137's face.<br><br>The findings included:<br><br>On 09/30/24 at 10:14 AM two surveyors observed Resident #137 in bed with a dressing on the left side of Resident #137's face that also covered the left ear with no date.<br><br>On 10/01/24 at 9:49 AM two surveyors observed Resident#137 in bed with a dressing on the left side of Resident #137's face that also covered the left ear with no date.<br><br>Record review of the demographic sheet for Resident#137 revealed an admitted [DATE] with diagnosis that included: Other specified disorders of left ear with left ear skin lesion and changes in skin texture.<br><br>Record review of a Significant Change in Status Minimum Data Set (MDS) with a reference date of 7/15/2024 Section C (Cognitive Status) revealed a Brief Interview for Mental Status (BIMS) score of 7 on a scale of 00-15, indicated moderate cognitive impairment. Section GG (Functional status) revealed Resident#137 required set up clean assistance for eating and personal hygiene, substantial/maximal assistance for shower/bathe and was dependent for toileting and transfers. Section I (Active diagnosis) revealed diagnosis of Basal Cell Carcinoma of skin of left ear and external auricular canal. Section M (Skin conditions) revealed Resident #137 received application of non-surgical dressings with or without topical medications other than to feet and application of ointments/medications other than to feet.<br><br>Record review of an Impaired skin integrity due to Basal Cell Carcinoma to left ear care plan for initiated on 7/23/24 with goals that included: lesion to left ear will decrease in size without signs and symptoms of infection through next review date revealed interventions that included: Staff to assess surgical site and inform the physician for any signs of infection. Apply gauze and secure with tape to top left ear as prescribed.<br><br>Record review of a physician's order sheet revealed orders dated 6/11/24 directions: clean very gently left ear skin lesion with normal saline, pat dry, apply gauze, secure with tape every day and as needed and 7/08/24 for Acetaminophen 500 milligrams (mg) tablet give two tablets by mouth once a day 30 minutes before skin treatment of the left ear for pain.<br><br>On 10/02/24 at 3:22 PM Staff B, Registered Nurse (RN) unit manager for the third floor stated, Each time the nurses change a dressing the new bandage should be dated to determine the last date it was changed. The only reason it should not be dated is if the dressing temporarily placed until a nurse can do a proper dressing change and date it. The dressing change for [Resident#137] should be done on the day shift.<br><br>(continued on next page) |

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|---|---|
| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 10/03/24 at 2:49 PM, the Director of Nursing (DON) stated, When a bandage is changed the date is changed at that time and should be written on the bandage to indicate the last date of change and by whom it was changed.<br><br>Record review of Policy entitled, Person Centered Quality of Care effective date: July 29, 2012, last revision date: August 10, 2014 last review date: January 7, 2024 Policy: The facility embraces, supports and has adopted a person-centered approach to care, services and treatment. The facilities identify and provide needed care and services that are resident centered, in accordance with the residents" preferences, goals for care and professional standards of practice that will meet each resident's physical, mental, and psychosocial needs. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48906<br><br>Based on observation, record review and interviews, the facility failed to provide an environment free from potential safety hazards for one resident (R#109) out of out of 18 residents with padded assist rails as evidenced by observations of two quarter side rails in the up position and one was without padding.<br><br>The findings included:<br><br>On 9/30/24 at 10:25 AM Resident #109 was observed in bed with eyes open, holding a toy. Two quarter length side rails observed in the up position. The right-side rail had a blue padding attached and the left side rail had no padding. There was a padding on the recliner near the resident. (see photos)<br><br>On 10/01/24 at 8:57 AM, Resident #109 was observed in bed, two quarter side rails noted in the up position. The left sided rail had no padding. There was a padding on the recliner near the resident. (see photos)<br><br>Record review of a demographic sheet for Resident #109 revealed an admitted [DATE] with diagnosis that included: Seizure.<br><br>Record review of a Significant Change in Status Minimum Data Set (MDS) with a reference date of 9/5/24 Section C (Cognitive Status) revealed a Brief Interview for Mental was undetermined and Section GG (functional status) revealed Resident#109 was dependent on staff for all Activities of Daily Living.<br><br>Review of a May 2024 physicians order sheet revealed an order for two assist rails up (in place) due to (seizure precautions) with padding every shift every day.<br><br>Record review of a Potential for injury due to seizure disorder care plan initiated on 9/12/2024 with a goal to not sustain any injury related to seizure disorder thru Next review date revealed interventions that included: two assist side rails down, horizontal, with padding to rails as prescribed.<br><br>On 10/03/24 at 12:14 PM; Staff B, Registered Nurse (RN) Unit Manager for the third floor was notified by surveyor of the observations and asked what is the order for Resident #109's side rails. Staff B, RN revealed, Resident #109 is ordered to have two padded side rails in the up position for seizure precaution to prevent injury. Upon admission if a resident has a history of seizure an order for side rails to be padded is received. All staff are responsible for ensuring the side rails are in the up position and padded by doing rounds. The only reason the padding would be removed is for hygiene care and it should be replaced.<br><br>On 10/03/24 at 12:29 PM Staff C, RN stated, The side rails for [Resident#109] are to be kept in the up position with padding for seizure precautions. I monitor the side rails to make sure they are in the correct position by doing rounds. Padding should be in place at all times.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 10/03/24 at 12:35 PM Staff E, Certified Nursing Assistant (CNA) (translated by ADON) when asked about the positioning of the side rails for Resident#109; Staff E stated, I am the CNA assigned to [Resident#109]. I am aware of the need for the side rails to be up and padded for safety measures. I am made aware of the interventions by the nurses during line up to inform every morning and rounds.<br><br>On 10/03/24 at 2:39 PM The Director of Nursing was informed by surveyor a concern of no padding on one side rail and the positioning of the side rail for Resident#109 and the DON revealed, there is a positioning device log that is used by staff and updated each morning to show all the residents with side rails and how they should be positioned. The purpose of padding the siderail is an extra measure to protect against trauma and friction for involuntary movements. If a resident has an order for side rails in the up position with padding. The padding should be on at all times while the resident is in bed, except during hygiene care and repositioning and it should be replaced; family are also educated to put it back in place if they remove it.<br><br>Record review of Policy entitled, Safety Management Plan effective date: January 1, 2014 Last revision date: December 16, 2014 Last reviewed date: January 24, 2024 Policy: The Palace manages risks within the environment that has minimal physical hazards and therefore, reduces the risk of injury. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51356<br><br>Based on observation, record review and interviews, the facility failed to follow infection control procedures and protocols for six residents (#73, #78, #14, #109, #115, #133) out of ten residents receiving enteral feedings as evidenced by observations of tube feeding connectors uncapped while feeding was not in progress.<br><br>The findings include:<br><br>During observation on 09/30/24 at 10:01 AM resident #73 was not in room; on the right side of the resident's bed A feeding bottle labeled [Formula Brand] was observed hanging on a pole, not in progress, and the connector tip was uncapped.<br><br>Review of the medical records for Resident # 73 revealed the resident was admitted to the facility on [DATE]. Clinical diagnoses included but not limited to: Dysphagia, oropharyngeal phase.<br><br>Review of the Physician's Orders Sheet (POS) for 10/01/2024 revealed the Resident #73 had orders that included but not limited to:<br><br>[formula] at 50 milliliters per hour via PEG (Percutaneous endoscopic gastrostomy) x (times) 18 hours. Special Instructions: Off at 8:00 AM. On at 2:00 PM, Every Shift, Day shift - Off 8:00 AM, Day shift - On 02:00 PM. Flush peg tube with 15 ml of H2O every shift. Every Shift, Day shift 7:00 AM - 07:00 PM, Night shift 07:00 PM - 07:00 AM. PEG site care Q (each shift and PRN (as needed) Every Shift, Day shift 07:00 AM - 07:00 PM, Night shift 07:00 PM - 07:00 AM.<br><br>Record review of Resident #73 's Significant Change Minimum Data Set (MDS) dated [DATE] revealed: Section C for Cognitive Patterns documented Brief Interview for Mental Status (BIMS) Score 0, on a 0-15 scale indicating the resident is severely cognitively impaired. Section GG (functional status) revealed Resident#73 is dependent on staff assistance for all ADLs (Activities of Daily Living.<br><br>Review of Resident # 73's Care Plans Reference Date 01/13/2021 revealed the Resident is at risk for complications related to tube feeding such as aspiration, infection, intolerance to feeding, fluid overload/deficits, etc. Resident will tolerate tube feeding without signs/symptoms of complications or infections and will remain patent.<br><br>48906<br><br>On 9/30/24 at 10:35 AM Resident#14 was in bed with eyes closed, A feeding bottle labeled [Formula Brand] was observed hanging on a pole, not in progress, and the connector was uncapped. A connector cap was observed on the pole. (photo evidence)<br><br>On 10/02/24 at 1:15 PM Resident #14 was in bed with eyes closed, A feeding bottle labeled [Formula brand]1.5 calorie was observed hanging on a pole, not in progress, and the connector was uncapped. A connector cap was observed on the pole. (see photo)<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Record review of demographic sheet for Resident #14 revealed an admitted [DATE], readmitted [DATE] with diagnosis that included: Encounter for attention to gastrostomy.<br><br>Record review of an Annual Minimum Data Set (MDS) with a reference date of 08/05/2024 in revealed Section C (Cognitive Status) a Brief Interview for Mental Status (BIMS) score of 00 indicating severe cognitive impairment and section GG (functional status) resident was dependent for all Activities of daily living (ADL).<br><br>Record review of a physician's order sheet for July 3, 2023 revealed orders for [Formula] calories via Percutaneous Gastronomy tube (PEG) at a rate of 60 milliliters per hour (ml/hr.) and auto flush water (H2O) via PEG at a rate of 45 ml/hr. for 20 hours every; the documented directions indicated: off at 10: 00 AM and on at 2:00 PM every day.<br><br>Review of Care Plan initiated on 8/13/24 with a goal for Resident to tolerate tube feeding without nausea/vomiting, diarrhea, constipation or aspiration by next review revealed interventions that included: [Formula brand] calories via PEG at 60 ml/hr. for 20 hours and auto flush of H20 at 45 ml/hr. via peg tube for 20 hrs. Maintain and improve current weight and stay hydrated<br><br>On 9/30/24 at 9:00 AM Resident #78 was observed in bed, the feeding bottle labeled [Formula brand] was hanging on pole next to bed. The feeding was not in progress, the tubing was suspended in the air with a connector piece that was uncapped.<br><br>On 10/01/24 at 9:07 AM Resident #78 was observed in bed. The feeding was hanging on the pole and not in progress was the tubing suspended in the air uncapped.<br><br>Record review of a demographic sheet for Resident #78 revealed resident was admitted to the facility on [DATE] with diagnosis that included: Gastrostomy status.<br><br>Record review of a quarterly MDS with a reference date of 9/09/2024 Section C (Cognitive Status) revealed the BIMS score was undetermined, and Section GG (functional status) revealed Resident#78 was dependent on staff assistance for all ADLs.<br><br>Record review of a Physician's order sheet for June 2024 revealed Resident #78 has orders for [Formula brand]feeding at a rate of 60 ml/hr. and an auto flush of H20 at a rate of 46 ml/hr. via PEG tube for 20 hrs. every shift on the day shift with directions to turn off at 10:00 AM and on at 2:00 PM every day.<br><br>Record review of a maintain and improve current weight and stay hydrated care plan initiated on 6/18/24 with a goal to tolerate tube feeding without diarrhea revealed interventions included: [Formula brand] calorie feeing at a rate of 60 ml/hr. via PEG for 20 hrs and an auto flush of water at 46 ml/hr. via peg tube for 20 hrs.<br><br>On 9/30/24 at 10:29 AM Resident #109 was observed in bed, A feeding bottle labeled [Formula brand] feeding hung on a pole, was not in progress, and the connector was without a cap.<br><br>On 10/02/24 at 1:55 PM Resident #109 was observed in bed, A feeding bottle labeled [Formula brand] hanging on a pole, was not in progress, and the connector had no cap.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Record review of demographic sheet for Resident #109 revealed an admitted [DATE] with diagnosis that included: Gastro-esophageal reflux disease without Esophagitis.<br><br>Record review of a Significant Change in Status MDS with a reference date of 9/5/24 Section C (Cognitive Status) revealed a BIMS score was undetermined, and Section GG (functional status) revealed Resident#109 was dependent on staff assistance for all ADLs.<br><br>Record review of a physician's order sheet for May 2024 revealed orders for [Formula brand] at 60 ml/hr. via PEG and an auto flush of H20 at a rate of 46 ml/hr. via PEG tube for 20 hrs off at 10:00 AM and on at 2:00 PM every day.<br><br>Record review of a at risk for Aspiration, GI, disturbances on care plan initiated on 9/12/2024 with a goal to tolerate tube feeding through NRD (Next Review Date) and tube feeding will remain patent without signs of infection revealed interventions included: Observe and report side effects and complication such as abdominal pain/ discomfort, constipation, diarrhea, aspiration, tube dysfunction, infection to Physician .<br><br>On 9/30/24 at 10:40 am Resident #115 was observed in bed with oxygen in progress at 2 L/min, no distress observed. A feeding bottle labeled [Formula] was hanging on the pole next to bed and the connector was uncapped.<br><br>On 10/01/24 at 8:59 AM Resident #115 was observed in bed with oxygen in progress at 2 L/min, no distress observed. A feeding bottle labeled [Formula] hanging on the pole next to bed and the connector was uncapped.<br><br>Record review of demographic sheet for Resident #115 revealed an admitted [DATE] and readmitted [DATE] with diagnosis that included: Encounter for attention to gastrostomy.<br><br>Record review of a MDS with a reference date of 9/10/24 Section C (Cognitive Status) revealed a BIMS score of 00, indicated severe cognitive impairment and Section GG (functional status) revealed resident was dependent on staff assistance for all ADLs<br><br>Record review of a physician's order sheet for September 2024 revealed orders for Jevity 1.5 at 35 ml/hr. and auto flush of H2O at 45 ml/hr. for 20 hours every shift off at 10:00 AM and on at 2:00PM every shift every day off at 10:00 AM and on at 2:00 PM.<br><br>Record review of an at risk for aspiration care plan initiated on 9/12/2024 with a goal for tube feeding site to remain patent without signs of infection through NRD revealed interventions included: Observe and report side effects and complication such as abdominal pain/ discomfort, constipation, diarrhea, aspiration, tube dysfunction, infection to Physician, check feeding tube placement patency every shift and as needed and tube feeding site care as prescribed by MD.<br><br>On 9/30/24 at 3:13 PM Resident#133 was observed in bed, no distress noted. A feeding bottle of [Formula Brand] was hanging on a pole next to resident's bed not in progress, and the connector was not capped.<br><br>(continued on next page) |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 10/01/24 at 9:11am Resident#133 was observed in bed, no distress noted. A feeding bottle of [Formula brand] was hanging on a pole next to resident's bed not in progress, and the connector was not capped.<br><br>Record review of demographic sheet for Resident#133 revealed an admitted [DATE] and a readmitted [DATE] with diagnosis that included: Encounter for attention to gastrostomy.<br><br>Record review of a Significant Change in Status MDS with a reference date of 8/6/24 Section C (Cognitive Status) revealed a BIMS score was undetermined, and Section GG (functional status) revealed Resident#133 was dependent on staff for all ADLs.<br><br>Record review of a maintain and improve current weight and stay hydrated care plan initiated on 6/18/24 with a goal to tolerate tube feeding without diarrhea revealed interventions that included: [Formula] at 70 ml/hr. via PEG x 20 hrs and Auto flush of H20 at 60 ml/hr. via peg tube x 20 hrs.<br><br>On 10/02/24 at 1:56 PM Staff A, Registered Nurse (RN) observed attempting to re-connect the feeding tube for Resident #14. Staff A, RN did not clean the connector and was stopped by surveyor. Staff A, RN was asked if the connector should be capped while feeding is not in progress and cleaned before being attached to resident, and Staff A, RN replied, The cap is supposed to be covered by the connector while feeding is off.<br><br>On 10/02/24 at 2:01 PM Staff A, RN was showed by surveyor the other residents (#73, #14, #78, R#109, R#115, #133) who had feeding tube with connectors uncapped. Staff A, RN stated, In this case I need to change the entire tubing and will do so now.<br><br>On 10/02/24 at 3:17 PM Staff B, Registered Nurse (RN) stated, When the tubing system for a feeding is disconnected from the resident, the connector should be placed into the cap for infection control purposes. When the nurses are ready to reconnect, they should remove from the cap and reconnect. For the instance when the connector is suspended in the air uncapped, the nurse should change the line and then reconnect.<br><br>On 10/03/24 at 2:46 PM The Director of Nursing (DON) stated, The night shift are responsible for setting up a new bottle and the day shift nurses reconnects the tubing. The connector should be capped while not in progress to prevent contamination. If a nurse finds it uncapped the whole system should be replaced.<br><br>Record review of Policy entitled, Infection Control program effective date: July 29, 2014, Last revised date: January 2021 last review date: March 27, 2024. Policy: The facility has established and maintains an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. |