STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	686123	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kendall Lakes Healthcare and Rehab Center	5280 SW 157 Avenue Miami, FL 33185

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 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. 45019 Based on observation, interview, and record review the facility failed to promote residents' dignity and respect during dining for two (Resident #62, Resident #380) out of 33 sampled residents. As evidenced by facility staff observed standing while feeding residents who required assistance with meals. The findings included: 1) On 04/17/24 at 01:18 PM during dining observation of residents, surveyor observed the Speech Therapist (Staff A) standing while feeding Resident #62. Speech therapist (Staff A) was asked why he was standing while feeding the resident, Staff A stated he was not aware that he was not allowed to stand and feed the resident, he immediately got a chair that was in the room, placed it close to the resident's bedside and continued to feed the resident. Interview on 04/18/24 at 09:22 AM. The Director of Nursing (DON) stated all staff including the rehabilitation department have been trained and are aware that they are supposed to be sitting down while feeding the residents. Currently I am providing further education and in-service to the staff regarding feeding residents. 48906 2) On 04/15/24 at 7:24 AM, Occupational Therapist observed standing while assisting Resident #380 to eat breakfast. Record review of Medicare 5 Day Minimum Data Set (MDS) 4/5/2024 Section C for cognitive status revealed a Brief Interview Mental Status score of six on a scale of zero to ten, indicated severe cognitive impairment. Section GG for functional status revealed Resident #380 was dependent for all Activities of Daily Living (ADL). Review of Resident # 380's care plan initiated 3/27/24 start date 4/10/24; revealed at risk for an alteration in nutrition and or hydration related to Intracerebral Hemorrhage and unable to feed self. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of physician orders revealed 3/26/24 a diet order for regular diet, regular texture, thin consistency, maintain aspiration precautions. On 04/15/24 at 7:46 AM the Occupational therapist stated: I was standing while feeding [Resident #380] breakfast, it is okay for me to be standing while assisting this resident to eat because she has weakness and I want to see how much she can do on her own. On 04/18/24 at 9:15 AM the Director of Nursing stated: staff are to be seated next to residents while assisting with meals to provide dignity. The Occupational therapist helps with assisting residents with meals. There is no reason he should be standing while actively assisting a resident with a meal. All staff are aware of this protocol, and we are doing in-services to reinforce this education for staff. I will do a teachable moment with the Occupational therapist. Review of the facility's policy and procedure titled Quality of Life-Dignity revision dated August 2009 indicates: Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality. Residents shall be treated with dignity and respect at all times. Review of the facility's policy with revision dated July 2017 titled, Assistance with Meals. Policy Statement: Residents shall receive assistance with meals in a manner that meets the individual needs of each resident. Policy Interpretation and Implementation. Dining Room Residents: 3. Residents who cannot feed themselves will be fed with attention to safety, comfort, and dignity, for example: a. Not standing over residents while assisting them with meals; Residents Requiring Full Assistance: 2. Residents who cannot feed themselves will be fed with attention to safety, comfort, and dignity, for example: a. Not standing over residents while assisting them with meals.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45019 Based on observation, record review and interview the facility failed to ensure pharmacy procedures were followed as per facility policy and medication reconciliation procedures were followed for one out of four medication carts observed/reviewed. There were 139 residents residing in the facility at the time of the survey. The findings included: On 04/17/24 at 10:01 AM during routine observation the surveyor observed the 400 Unit Medication Cart # 1, computer screen opened to resident's medication screen and the medication cart was unlocked in the 400-406 hallway, no staff in attendance at the cart; surveyor went looking for the assigned Registered Nurse (Staff C), Staff C was found in front of room [ROOM NUMBER], and stated she was sorry the cart was left unlocked and unattended, and it was her mistake. On 04/17/24 at 11:50 AM During medication cart observation with Registered Nurse (Staff D) assigned to the 500-unit Medication Cart #3. The narcotic count for Resident #87 was incorrect-The count on the bingo card for Resident #87's Dilaudid (Hydromorphone HCl) Oral Tablet 2 Milligrams (MG) was ten (10), the narcotic sheet for the resident documented amount remaining eleven (11) signed out on 4/17/24 at 9:39AM. On 4/17/24 at 11:58 AM Registered Nurse (Staff D) stated she gave two (2) Hydromorphone 2 MG pills to Resident #87 but recorded only one (1) pill given on the resident's narcotic sheet by mistake. Staff D then proceeded to call the Nursing Supervisor for the unit (Staff E) over to the cart, explained to her documentation discrepancy and stated she will be making the correction immediately on the resident's narcotic sheet with the charge nurse (Staff E) as the witness. Interview on 04/17/24 at 10:52 AM. The Director of Nursing (DON) stated: I am going to provide in-service to the Registered Nurse (Staff C) immediately regarding leaving her cart and computer screen unlocked. Interview on 4/18/24 at 10:00 AM; the Director of Nursing (DON) stated she was told what happened with the narcotics on staff D's Medication Cart and is currently providing in-services to all the nursing staff regarding medication reconciliation procedures. Review of the medical records for Resident #87 revealed the resident was admitted to the facility on [DATE] with orders that included: Dilaudid Oral Tablet 2 MG (Hydromorphone HCl)-Give 2 tablets by mouth every 4 hours as needed for moderate pain (scale 4-6) related to low back pain. Review of the facility's policies and procedures titled Reconciliation of Medications revised July 2017 states: The purpose of this procedure is to ensure medication safety by accurately accounting for the resident's medication, routes and dosages upon admission or readmission to the facility. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policies and procedures titled Security of Medication Cart revised April 2007 documents: The medication cart shall be secured medication passes. medication carts must be securely locked at all times when out of the nurse's view. Review of the facility's policies and procedures titled Protected Health Information, Management and Protection of revised April 2014 states: Protected Health Information (PHI) shall not be used or disclosed except as permitted by current federal and state laws. It is the responsibility of all personnel who have access to resident and facility information to ensure that such information is managed and protected to prevent unauthorized release or disclosure.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 45019 Based on observation, interview, and record review the facility failed to ensure the lint screens for two out of three dryers observed in the laundry room were cleaned as per facility protocol. There were 139 residents residing in the facility at the time of the survey. The findings included: On 04/17/24 at 09:23 AM during an observational tour of the laundry area by two surveyors on the team with the facility's Infection Preventionist (Staff B) and the Director of housekeeping, the lint screens of two out of three clothes dryers were checked and observed covered in a thick layer of lint. Each dryer has a load capacity of 150 pounds and was in working order. On 4/17/24 at 9:40AM, the Director of housekeeping acknowledged that the lint screens for the two dryers were full of lint and was not cleaned, the lint log posted on the wall opposite the dryers documented-the lint screens were last cleaned on 4/17/24 at 9:00 AM. The Director of Housekeeping stated that the dryer lint screens are supposed to be cleaned every hour by the staff on duty. Review of the undated facility policy titled Lint states: All lint screens must be cleaned and brushed every hour and after every single load. If a lint screen is not cleaned out, the air passing through the machine will be blocked, which will raise the temperature in the machine, possibly causing a hazardous situation.