

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 105680	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/30/2020
NAME OF PROVIDER OF SUPPLIER NSPIRE HEALTHCARE LAUDERHILL		STREET ADDRESS, CITY, STATE, ZIP 2599 NW 55TH AVE LAUDERHILL, FL 33313	
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 0584 Level of harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation and interview, the facility failed to have an environment that was sanitary and clean. Multiple area's in the facility was observed to have paper on the floor, an unknown brown substance was observed on the floor in the hallway on the South Wing of the facility, food was on the floor in the hallway, multiple dark stains were observed in the carpet and an overflowing garbage can was observed in the corridor next to the nurses station on the North Wing. The finding included: During a tour of the facility on 4/30/2020 starting at 8:54pm, the following was observed: (a) On the South 200's wing, torn pieces of paper were observed on the floor in the hallway, a cup was on the floor in the hallway, food was on the floor, a piece of plastic was on the floor, and a brown smeared substance was on the floor in the hallway. (b) An empty cup was noted on a handrail in the corner of the South 100's wing. (c) Multiple dark stains were noted in the carpet on the South Wing. (d) On the North wing, a garbage can was overflowing with garbage on the side of the nurses station. At 9:30pm on 4/30/20, the Maintenance Director was interviewed about the environment and it was reported the floors are cleaned daily and renovations are planned for the facility.		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE (X6) DATE	

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.