STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105030	A. Building B. Wing	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Miami Jewish Health Systems, Inc	5200 NE 2nd Avenue Miami, FL 33137

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, records reviewed and interviews, the facility's staff failed to adequately supervise one (Resident #1) of two vulnerable residents sampled had falls resulting in injuries. On 02/25/2026 vulnerable Resident #1 was left unattended in an unlocked wheelchair by Certified Nursing Assistant Staff A; the wheelchair rolled away and Resident #1 fell from the wheelchair, hit his head on the pavement and sustained major head injuries. There were 235 residents residing in the facility at the time of survey. The findings included: Observation on 3/18/26 at 11:42 AM of the facility's video footage dated 2/25/2026 timestamped 2:30 PM showed Staff A, Certified Nursing Assistant (CNA) escorting Resident #1who was seated in a wheelchair to the door of the auditorium. Staff A, CNA left Resident #1 at the door, did not lock the wheelchair and went inside the auditorium leaving Resident #1 outside. While Staff A, CNA was inside the auditorium, Resident #1's wheelchair started rolling until it came in contact with the sidewalk and Resident#1 fell out of the wheelchair and hit the pavement. A few moments later Staff A, CNA exited the auditorium and checked on Resident #1. Record review of nursing notes dated 2/25/2026 revealed Resident #1 was assessed at approximately 2:30 PM downstairs near the auditorium and found to have sustained a laceration to the left forehead with significant bleeding. An ambulance arrived and transported the resident to a nearby hospital for further evaluation.Record review of nursing notes dated 2/26/2026 indicated the hospital was contacted and revealed Resident#1 had a diagnosis of cerebral brain bleed.Clinical records revealed Resident #1 was admitted to the hospital from [DATE] and returned to the facility on [DATE].Review of Resident #1's hospital records after the incident indicated the resident sustained a contusion and laceration of the cerebrum and brain hemorrhage.Review of Resident #1's clinical records revealed the resident was admitted on [DATE] and readmitted on [DATE] with diagnoses that included: Fall from non-moving wheelchair, Contusion and Laceration of Cerebrum and injury without loss of consciousness, Diffuse Traumatic brain injury with loss of consciousness, Dementia, Functional Quadriplegic and Left-hand Contracture. Record review of Resident #1's fall scale assessments dated 2/15/22, 4/11/22, 4/16/22, 7/17/22, 8/10/22, 3/1/26, 2/04/24, 11/23/25, and 2/23/26 revealed Resident#1 was at a High Risk for falls. Review of Resident #1's fall history revealed the resident sustained falls on 04/11/2022, 04/16/2022, 08/09/2022, 02/04/2024, 02/15/2024 and 02/25/26.Record review of Resident #1's Order Summary Report revealed orders dated 11/20/24 to provide falls precautions as care planned every shift for prevention of falls.Record review of care plans initiated: 02/21/2022 and revised: 02/05/2024 problem focus indicated Resident #1 is at high risk for falls related to history of falls, impaired mobility, difficulty communicating needs, unsteady gait, poor safety awareness, muscle weakness, left side weakness, side effects of psychotropic medications, overestimates ability, adamant to keep his independence with interventions that included: Close supervision, encourage resident to stay in supervised area when in wheelchair and provide safety reminders during rounds and offer assistance with toileting and care. Record review of a Discharge Return Anticipated Minimum Data Set reference dated 2/25/2026 Cognitive Section revealed a Brief Interview of Mental Status (BIMS) score of three out of fifteen (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0689 Level of Harm - Actual harm Residents Affected - Few	indicating severely impaired cognition; Functional Abilities and Goals section indicated Resident #1 required substantial/maximal assistance for toilet transfer/ sit to stand/ chair/bed-to-chair transfer. During a telephone interview on 3/18/26 at 11:26 AM Staff A, CNA stated: [Resident#1] asked to be taken to the auditorium, so I took the resident to the door of the auditorium asked [Resident#1] to wait while I looked inside. When I returned, I saw [Resident#1] was on the ground, laying on stomach. I went inside to get help, and the Patient Assessment Team was called and assessed the resident. I saw there was a cut on the side of the resident's face. Emergency services came and took the resident to the hospital. I don't remember locking the wheelchair. I am aware the wheelchair should be locked. On 3/18/26 at 2:11 PM Resident #1 was observed in the dining room area seated in a wheelchair next to Staff B, CNA. Resident #1 did not respond when greeted and showed little to no facial expressions and a scar was noted on the left side of his forehead.Interview on 3/18/26 at 2:12 PM Staff B, CNA stated, I am the one to one (1:1) monitor assigned to [Resident #1]. I assist the resident with all the ADLs (Activities of Daily Living) and sometimes the resident talks to me. I notice this resident did not need as much assistance before the fall.Interview on 3/18/25 at 2:15 PM Staff C, Licensed Practical Nurse (LPN) stated, I am the nurse assigned to [Resident #1] today and since the resident returned, I have noticed a slower response time. He now requires maximum assistance.During an interview on 3/18/2026 at 3:25 PM the Risk Manager stated: I was informed about the fall on 2/25/2026 and [Resident #1] was transferred to the hospital and the next day a report was received that a cerebral bleed was sustained, at that time I reported it to state agencies. It was initially reported to me that [Resident #1] attempted to get out the wheelchair however the CNA involved could not remember if the wheelchair was locked. I viewed the video footage that confirmed the wheelchair was not locked and determined to be negligent on our part. During that time Staff A, CNA was placed on administrative leave.Review of the facility's Policy titled Fall Prevention Effective Date: 12/1990 with Revision Dates 03/2020 and 03/2022 indicated:PURPOSE: To ensure the safety and well-being of all Miami Jewish Health residents by identifying risk factors and interventions to reduce the likelihood of Falls.POLICY: It is the policy of Miami Jewish Health to take steps to reduce the number and severity of resident falls through appropriate assessment, evaluation, investigation, root cause analysis, identification of risk factors, and interventions that are appropriate for the resident, in order to prevent occurrence, re-occurrence and reduce the likelihood of significant injury.