

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105120	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2025
NAME OF PROVIDER OR SUPPLIER Serenity Bay Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 16650 W Dixie Hwy North Miami Beach, FL 33160	
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 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. Based on observations, interviews and record reviews facility failed to store and prepare food in a sanitary manner in the kitchen as evidenced by milk box temperature measured at 50 degrees Fahrenheit, a refrigerated serving of nectar thick milk temperature measured at 51 degrees Fahrenheit, a personal item on top of dishwasher, and a kitchen staff member with a beard not wearing a beard covering. These deficient practices had the potential to result in food borne illness for all residents who consume food prepared in the facility's kitchen. There were 129 residents residing in the facility at the time of survey. The findings included: During the initial kitchen tour on 12/01/2025 at 10:10 AM in the presence of the Kitchen Manager; the Milk Box Refrigerator temperature was measured at 50-degree Fahrenheit (degrees F). A serving of nectar thick milk observed in the Milk Box, temperature was measured at 51 degrees F. Refrigerator #2 temperature measured at 42 degrees F. (The required temperature range for refrigerators and cold foods is at or below 41 degrees F). The Kitchen Manager was present during the temperature review. The dishwasher sanitizer test strips that were in use had an expiration date of October 1, 2025. After the surveyor notified the Kitchen Manager of the identified concern, the Kitchen Manager presented new unexpired test strips. At 11:00 AM on 12/01/2025, an observation was made of Styrofoam cup on top of the dishwashing machine. Staff E, Porter, was in the kitchen standing beside the dishwashing machine. The Surveyor notified the Kitchen Manager of the identified concern. The Kitchen Manager questioned Staff E, [NAME] about the Styrofoam cup. Staff E, [NAME] stated, was hot picked up the cup, and took a sip. The Kitchen Manager instructed Staff E, [NAME] to discard the cup. Staff E, [NAME] dumped the remaining liquid into a utensil bin. The Kitchen Manager told Staff E, Porter, You cannot do that and send the bin through the dishwasher alone due to contamination. On 12/01/25 at 11:50 AM during the kitchen tour staff member (Staff A, Porter) with a beard was observed carrying a tray of food without wearing a beard covering. Interview on 12/01/25 at 11:50 AM Staff A, [NAME] was asked about the facility's protocol for hair coverings in the kitchen. Staff A stated: I am new here and I was told to wear a covering. Surveyor asked Staff A, [NAME] why staff was not wearing a beard covering and Staff A, [NAME] replied They give me the covering. No beard coverings were observed in the kitchen at the time. Interview on 12/01/25 at 11:55 AM The Kitchen Manager was notified of the identified concern and stated, Staff are aware they need to wear a beard covering. Surveyor asked, Where are the beard coverings kept? The Kitchen Manager retrieved beard coverings from office and placed them in front of kitchen next to the hair nets. (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
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a follow up kitchen tour on 12/02/25 at 12:15 PM revealed Staff A, [NAME] observed in kitchen wearing a surgical mask. Kitchen manager made aware and instructed staff to wear a beard covering. On 12/02/25 at 12:15 PM, the Kitchen Manager was interviewed about facility's protocol for wearing hair coverings and stated, Upon hire staff are trained to wear hair and beard coverings. I keep the coverings at the front. The coverings were not at the front yesterday because only one staff member uses it. The coverings are important to prevent any hairs from entering the food. Hair coverings must be worn upon entering the kitchen. Record review of a policy titled Dietary Employee Personal Hygiene implemented on 5/1/23 reviewed on 5/1/24 and revised on 5/1/25 revealed Policy: It is the policy of this facility to utilize the following as guidelines for employee personal hygiene to prevent contamination of food by foodservice employees. Policy Explanation and Compliance Guidelines: 4. Hair Restraints All dietary staff must wear hair restraint (e.g., hairnet, hat and/or beard restraint) to prevent hair from contacting food. Head coverings must be clean.		

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on observations, interview, and record review, the facility failed to demonstrate and implement effective plan of actions to correct identified quality deficiency in the problem areas related to repeated deficient practice for F656-Develop/Implement Comprehensive Care Plan; F690-Bowel/Bladder; F761- Label/Store Drugs and Biologicals.; F812- Food Procurement, Store/Prepare/Serve Sanitary; there were 129 residents residing in the facility at the time of survey. The findings include. Record Review of the facility's survey history revealed, during a recertification conducted on June 17, 2024, through June 20, 2024, F656-Develop/Implement Comprehensive Plan. F690-Bowel/Bladder Incontinence, Catheter, UTI F761-Label/Store Drugs and Biologicals F812- Food Procurement, Store/Prepare/Serve Sanitary was cited as the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food services safety during observations. Review of the facility Policy and Procedure titled Quality Assurance and Performance Improvement (QAPI) dated 05/01/2023 and revised on 05/01/2025 states: It is the policy of the facility to develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. Interview with the Administrator/Quality Assurance (QA) and Director of Nursing (DON) on 12/04/2025 at 4:38 PM, stated: The QAPI meetings are normally held on the third Wednesday of every month where we discuss the previous months. The last meeting was held on 11/19/2025 and we discussed the issues and findings for the month of October. The committee consists of: Director of Nursing (DON), Assistant Director of Nursing (ADON), Infection Preventionist, Medical Director, Registered Dietitian, Rehab Director, Nursing Supervisors, Social Services Director, Activities Director, Housekeeping Director, Administrator, and admission Director. In these meetings, we discuss opportunities for improvement focusing on quality of care/life, and resident safety. We address any gaps in the system for that goal of patient centered care if there were any gaps observed.		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observations, interviews and record review, the facility failed to secure confidential information for residents on one (Unit 1) out of 3 units as evidenced by paperwork with residents' medical information left visible and unattended at the Unit 1 nursing station and an open, unattended computer screen with resident information visible on The Unit 1 medication cart 1. There were 129 residents residing in the facility at the time of the survey. The findings included: 1. Observation on 12/01/25 at 12:58 PM revealed unattended medical information with residents' names at the Unit 1 nursing station. Interview on 12/01/25 at 1:05 PM, the Unit 1 Registered Nurse Manager was apprised of the identified concern. The Registered Nurse Manager stated: No information should be viewable to people as they walk by. Even on computers all information should be kept private. 2. Observation on 12/04/25 at 10:38 AM revealed an open unattended computer screen on the Unit 1 medication cart 1 with residents' information visible. Staff H, Registered Nurse acknowledged the identified concern and closed the computer screen. Record review of a policy titled HIPAA Sanctions implemented on 5/1/23, reviewed on 5/1/24 and revised on 5/1/25 revealed Policy: It is the policy of this facility to apply sanctions against employees who fail to comply with all policies and procedures regarding the protection of our residents' personal identifiable health information. Policy Explanation and Compliance Guidelines: 2. All employees are expected to comply with all policies and procedures regarding the protection of personal identifiable health information of our residents. 6. Examples of violations include but are not limited to: a. Accessing information that is not within the scope of the employee's duties. E. Leaving a secured application unattended while logged on.		

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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** Based on observations, record reviews and interviews the facility failed to implement the care plans for two (Resident #139 and Resident #142) out of two sampled as evidenced by: 1) The facility's staff positioned Resident #139's indwelling urinary catheter drainage collection bag above the bladder on the bed's side rail, causing backflow of urine in the tubing. 2) Facility staff failed to administer oxygen at the correct delivery flow rate setting for Resident # 139. 3) Facility's staff failed to follow infection control protocol related to Enhanced Barrier Precaution for Resident #142. The findings included:Resident #1391) During an observation on 12/02/25 at 4:50 PM, Staff C, Certified Nurse Assistant (CNA) was noted in Resident 139's room providing assistance. After Staff C, CNA exited Resident #139's room it was noted that the indwelling urinary drainage collection bag was anchored to the bed's side rail above the level of the bladder, and a back flow of urine was observed in the tubing. (photo evidence).Record review of a demographic sheet revealed Resident#139 was admitted on [DATE] with diagnoses that include but not limited to: Obstructive Uropathy, Urinary Tract Infection and End Stage Renal Disease.Record review of a care plan initiated and revised on: 11/20/25 revealed Resident #139 had an indwelling urinary catheter for Obstructive Uropathy with a goal to be/remain free from catheter-related trauma through review date and show no signs or symptoms of Urinary infection with interventions that included: Please position catheter bag and tubing below the level of the bladder. Interview on 12/01/25 at 4:55 PM, Staff B, Registered Nurse (RN) was notified of the above identified concern. Staff B, RN stated: I round every two hours to ensure proper placement. When I came on shift the bag was below the level of the bladder.Interview on 12/01/25 at 5:23 PM, Staff C, CNA stated, I take care of residents with catheters and make sure the bag is inside a cover, not touching the ground and below the level of bladder. I did not notice the bag was on the side rail when I was in the room.On 12/04/25 at 2:32 PM, the Director of Nursing (DON) stated, Staff are to position the bag below the level of the bladder because back flow can cause a UTI.2) Observation on 12/02/25 at 4:50 PM revealed Resident#139 in bed receiving oxygen via nasal cannula at a rate of 5 Liters Per Minute (LPM) (photo evidence).Record review of a demographic sheet revealed Resident#139 was admitted on [DATE] with diagnosis that included: Chronic Obstructive Pulmonary Disease (COPD), Acute Respiratory Failure with Hypoxia and Pleural Effusion.Record review of a physician's order sheet revealed an order dated 11/19/25 directions: Oxygen at 4 LPM via nasal canula continuously every shift for preventative measures.Record review of a care plan initiated and revised on: 11/20/25 revealed Resident#139 had a diagnosis of COPD and was at risk for complications with a goal to maintain optimal breathing and interventions that included: Oxygen at 4 LPM via nasal canula continuously.On 12/01/25 at 4:55 PM, Staff B, Registered Nurse (RN) stated was notified of the identified concern. Staff B, RN stated: The oxygen should be delivered at 4 LPM. Resident # 1423) Observation on 12/04/25 at 10:11 AM revealed Staff D, Registered Nurse (RN) provided Resident #142's tracheostomy care and was not wearing a disposable gown throughout the procedure.Record review of a demographic sheet revealed Resident#142 was initially admitted on [DATE] and readmitted on [DATE] with diagnosis that included: Tracheostomy status.Record review of a physician's order sheet revealed an order dated 11/21/25 directions: Enhanced Barrier Precaution (EBP) to prevent transmission of multidrug-resistant organism (MDRO) related to presence of tracheostomy every shift for EBP protocol.Record review of a Minimum Data Set (MDS) reference dated 11/26/25 revealed Resident#142 had a Brief Interview for Mental Status score of 15, indicated no cognitive impairment, received substantial assistance for Oral hygiene and received Tracheostomy care, continuous oxygen therapy, and suctioning as needed.Record review of a care plan initiated on 11/21/25 and revised on: 11/30/25 revealed Resident#142 required Enhanced Barrier Precautions (EBP) related to Tracheostomy with interventions that included: Providers and staff must wear gown (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and gloves for the high contact care areas which include: dressing bathing/showering transferring changing linens, providing hygiene changing briefs, or assisting to toileting device care use: central line urinary catheters, feeding tube tracheostomy/ventilator wound care any skin opening requiring a dressing. Interview on 12/04/25 at 10:28 AM, Staff D, RN stated: I should have worn a gown, gloves, and face mask because Resident#142 is under Enhanced Barrier Precaution. I didn't put it on because I missed that part. Record review of the facility's policy titled Comprehensive Care Plan implemented on 5/1/23, revised and reviewed on 5/1/24; 5/1/25 revealed Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality.		

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F 0689 Level of Harm - Minimal harm or potential for 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, record reviews, and interviews, the facility created an unsafe environment with potential accidents and hazards for one resident (Resident #64) out of 2 residents sampled. An electrical cord extended from a wall to behind Resident #64's bed, causing a tripping hazard. This deficient practice increased the risk of accidents and hazards that could have caused serious harm or injuries. The facility had 129 residents at the time of the survey. The findings include. Observation on 12/02/2025 at 11:07 AM, in Resident's #64's room revealed the resident was not in the room. An electrical cord was observed extending from the wall to behind the resident's bed. (Photo Evidence) Observation on 12/02/2025 at 12:34 PM, in Resident #64's room revealed an electrical cord still extending from the wall to behind resident's bed (Photo Evidence). On 12/02/2024 at 12:56 PM, the Director of Nursing (DON) acknowledged the identified concern and stated: Oh, that is not supposed to be there.this is an old building and there are not enough plugs. I will remove it now. Record Review of Resident #64's demographic sheet revealed the resident was initially admitted on [DATE] and readmitted on [DATE] with diagnosis that included but not limited to idiopathic Normal Pressure Hydrocephalus. Record Review of Quarterly Minimum Data Set (MDS) reference dated 11/19/2025 revealed Resident #64 is severely cognitively impaired and has no impairment to upper/lower extremities but uses walker and wheelchair and receives antipsychotics on a routine basis. Record Review of a Care Plan with start date 07/15/2025, last revised on 06/03/2025 revealed Resident #64 was at risk for falls due to history of falls and unsteady gait. Goal: Resident #64's risk of falls will have decreased through next review date. Intervention; Keep Resident #64's environment clear of clutter and obstacle. Interview on 12/04/2025 at 09:33 AM the Maintenance Director stated: I do not know why the electric cable was plugged that way because it is supposed to be plugged behind the bed. The reason for plugging it behind the bed is to prevent someone possibly tripping and falling if a cable is in the way. The facility's protocol for accident hazards is to ensure that all cables are not in any area where it can cause any person to fall or have any type of accident. During an interview on 12/04/2025 at 01:38 PM, Staff F, Licensed Practical Nurse (LPN) stated: Electronic cords should be plugged in the nearest outlet to the bed but behind the bed, not across like it was. If the outlet behind the bed is broken, we would need to call maintenance and notify them. I think maintenance was aware of the electronic cord being plugged where you found it. Honestly, I did not notice the cord when I made my rounds. Record Review of the facility's Policy and Procedure titled Accident Hazards dated 05/01/2023, revised 05/01/2025 indicated: Policy: The resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistive devices to prevent accidents. This includes: Identifying hazard(s) and risk(s)Evaluating and analyzing hazard(s) and risk(s)Policy Explanation and Compliance Guidelines:Identification of Hazards and Risks- the process through which the facility becomes aware of potential hazards in the resident environment and the risk of a resident having an avoidable accident.a. All staff (e.g. professional, administrative, maintenance, etc.) are to be involved in observing and identifying potential hazards in the environment, while taking into consideration the unique characteristics and abilities of each resident.b. The facility should make a reasonable effort to identify the hazards and risk factors for each resident.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews, the facility's staff position an indwelling urinary catheter drainage bag and tubing in accordance with professional standards of care for one (Resident#139) out of three sampled residents, who had an indwelling urinary catheter. The facility's staff positioned Resident#139's indwelling urinary catheter drainage collection bag above the bladder on the bed's side rail, causing backflow of urine in the tubing. This increased the risk of catheter-associated urinary tract infections and other serious medical issues. Ten residents with indwelling urinary catheters resided in the facility at the time of the survey. The findings include: During an observation on 12/02/25 at 4:50 PM, Staff C, Certified Nurse Assistant (CNA) was noted in Resident 139's room providing assistance. After Staff C, CNA exited Resident #139's room it was noted that the indwelling urinary drainage collection bag was anchored to the bed's side rail above the level of the bladder, and a back flow of urine was observed in the tubing. (photo evidence). Record review of a demographic sheet revealed Resident#139 was admitted on [DATE] with diagnoses that include but not limited to: Obstructive Uropathy, Urinary Tract Infection (UTI) and End Stage Renal Disease. Record review of a care plan initiated and revised on: 11/20/25 revealed Resident #139 had an indwelling urinary catheter for Obstructive Uropathy with a goal to be/remain free from catheter-related trauma through review date and show no signs or symptoms of Urinary infection with interventions that included: Please position catheter bag and tubing below the level of the bladder. Record review revealed the admission Medicare 5-day Minimum Data Set (MDS) reference dated 11/22/25 was in progress. Interview on 12/01/25 at 4:55 PM, Staff B, Registered Nurse (RN) was notified of the above identified concern. Staff B, RN stated: I round every two hours to ensure proper placement. When I came on shift the bag was below the level of the bladder. Interview on 12/01/25 at 5:23 PM, Staff C, CNA stated, I take care of residents with catheters and make sure the bag is inside a cover, not touching the ground and below the level of bladder. I did not notice the bag was on the side rail when I was in the room. Interview on 12/03/25 at 1:08 PM, the Infection Control Preventionist stated, I educate staff on ways to prevent urinary infections that include proper perineal care and to ensure the tubing is below the level of the bladder and not kinked because urine can reflux back into the bladder and cause urinary infection. On 12/04/25 at 2:32 PM, the Director of Nursing (DON) stated, Staff are to position the bag below the level of the bladder because back flow can cause a UTI. Record review of the facility's policy titled Preventing Urinary Tract Infection implemented on 5/1/23, revised and reviewed on 5/1/24; 5/1/25 revealed Policy: Policy: To reduce the incident of urinary tract infection in patients and residents by using evidence-based practice for hygiene, hydration, catheter care and early identification of risk factors.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and records reviewed, the facility failed to provide adequate respiratory care and services for one (Resident#139) out of two sampled residents receiving oxygen therapy, as evidence by inaccurate oxygen delivery flow rate setting for Resident # 139. This deficient practice increases the risk for worsening respiratory conditions with the potential of an adverse effect. There were 129 residents residing in the facility at the time of survey. The findings included: Observation on 12/02/25 at 4:50 PM revealed Resident#139 in bed receiving oxygen via nasal cannula at a rate of 5 Liters Per Minute (LPM) (photo evidence). Record review of a demographic sheet revealed Resident#139 was admitted on [DATE] with diagnosis that included: Chronic Obstructive Pulmonary Disease (COPD), Acute Respiratory Failure with Hypoxia and Pleural Effusion. Record review of a physician's order sheet revealed an order dated 11/19/25 directions: Oxygen at 4 LPM via nasal cannula continuously every shift for preventative measures. Record review of a care plan initiated and revised on: 11/20/25 revealed Resident#139 had a diagnosis of COPD and was at risk for complications with a goal to maintain optimal breathing and interventions that included: Oxygen at 4 LPM via nasal cannula continuously. On 12/01/25 at 4:55 PM, Staff B, Registered Nurse (RN) stated was notified of the identified concern. Staff B, RN stated: The oxygen should be delivered at 4 LPM. On 12/04/25 at 2:32 PM The Director of Nursing (DON) revealed Nurses are to follow physician orders when administering oxygen. Record review of the facility's policy titled Physician Orders implemented on 5/1/23, revised and reviewed on 5/1/24; 5/1/25 revealed Policy: It is the policy of the facility to ensure Physician Services are in accordance with State and Federal regulations. Procedure: 6. All physician orders must be followed as prescribed, and if not followed, the reason must be recorded on the resident's medical record during that shift.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations reviewed and interview the facility's staff failed to maintain the medication refrigerator temperature within the required range of 36 degrees Fahrenheit to 46 degrees Fahrenheit in one out of three medication room refrigerators. The refrigerator thermometer in Unit 3's medication room displayed a reading of 55 degrees Fahrenheit. There were 129 residents that resided in the facility at the time of survey. The findings include. Observation on 12/03/2025 at 10:48 AM, of the Unit 3 medication room with Staff F, a Licensed Practical Nurse (LPN) revealed the temperature log outside the refrigerator was last signed on 12/03/2025 with a documented temperature reading of 39 degrees Fahrenheit. However, the thermometer inside the refrigerator indicated a reading of 55 degrees Fahrenheit. Staff F, LPN stated I do not know what the proper temperature for the refrigerator should be. Interview on 12/03/2025 at 2:24 PM, the Pharmacist stated The medication room refrigerator temperature should be between 36-46 degrees Fahrenheit. Record Review of the facility policy on Medication Storage 05/01/2023 states Refrigerated Products: 1. All medications requiring refrigeration are stored in refrigerators located in the pharmacy and at each medication room. 2. Temperatures are maintained within 36-46 degrees F. Charts are kept on each refrigerator and temperature levels are recorded daily by the charge nurse or other designee.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews, the facility's staff failed to follow infection control protocol related to Enhanced Barrier Precaution for one resident (Resident #142) out of two sampled residents. The staff member did not wear the required Personal Protective Equipment during tracheostomy care, which increases the risk of transmitting Multidrug-Resistant Organisms. At the time of the survey, 129 residents resided in the facility. The findings included: Observation on 12/04/25 at 10:11 AM revealed Staff D, Registered Nurse (RN) provided Resident #142's tracheostomy care and was not wearing a disposable gown throughout the procedure. Record review of a demographic sheet revealed Resident#142 was initially admitted on [DATE] and readmitted on [DATE] with diagnosis that included: Tracheostomy status. Record review of a physician's order sheet revealed an order dated 11/21/25 directions: Enhanced Barrier Precaution (EBP) to prevent transmission of multidrug-resistant organism (MDRO) related to presence of tracheostomy every shift for EBP protocol. Record review of a Minimum Data Set (MDS) reference dated 11/26/25 revealed Resident#142 had a Brief Interview for Mental Status score of 15, indicated no cognitive impairment, received substantial assistance for Oral hygiene and received Tracheostomy care, continuous oxygen therapy, and suctioning as needed. Record review of a care plan initiated on 11/21/25 and revised on: 11/30/25 revealed Resident#142 required Enhanced Barrier Precautions (EBP) related to Tracheostomy with interventions that included: Providers and staff must wear gown and gloves for the high contact care areas which include: dressing bathing/showering transferring changing linens, providing hygiene changing briefs, or assisting to toileting device care use: central line urinary catheters, feeding tube tracheostomy/ventilator wound care any skin opening requiring a dressing. Interview on 12/04/25 at 10:28 AM, Staff D, RN stated: I should have worn a gown, gloves, and face mask because Resident#142 is under Enhanced Barrier Precaution. I didn't put it on because I missed that part. Record review of the facility's policy titled Enhanced Barrier Precautions implemented on 5/1/23, revised and reviewed on 5/1/24; 5/1/25 revealed Policy: It is the policy of the facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms.		