

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

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

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>105172                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                  | (X3) DATE SURVEY<br>COMPLETED<br><br>07/28/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Fountain Manor Health & Rehabilitation Center                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>390 NE 135th St<br>North Miami, FL 33161 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                       |                                                 |
| F 0600<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, interviews and record review the facility failed to protect the residents right to be free from physical abuse for one (Resident #1) out of three sampled residents as evidenced by a federal report submitted by the facility regarding a verified allegation of physical abuse from a staff member towards Resident #1. There were 130 residents residing in the facility at the time of survey. The findings Included: On 7/22/25 the facility submitted a federal report [] alleging Resident #1 was physically abused by Mental health technician, Staff A. On 7/28/25, The facility verified the allegation and terminated Staff A's employment. On 07/28/2025 Resident #1 was observed seated on the patio in stable condition. On 7/28/25 at 9:55 AM Resident #1 was interviewed (translated by other surveyor on the team) about the allegation and stated, I am pleased with the staff except one person. That staff hit me, I fell to the floor, and he dragged me to my room. Record review of Resident #1's demographic sheet revealed the resident was admitted on [DATE] with diagnosis that include: Dementia, psychosis, Encephalopathy, Depression, Syncope and collapse, Repeated falls, Difficulty in walking, and Osteoarthritis. Record review of a Quarterly Minimum Data Set (MDS) with a reference date of 7/8/25 indicated Resident #1 is moderately impaired cognitively, had no behavior concerns, was independent for activities of daily living and required chair/bed-to-chair transfers. Record review of a care plan initiated on 5/21/25 and reviewed/revised on 7/24/25 revealed Resident #1 exhibited behaviors: spitting at staff and attempting to hit a staff member with her shoe with interventions that included: Maintain safe distance during episodes of aggression. Record review of Resident #1's Physicians Orders Sheet for March 2025 revealed orders included Memantine 5 milligrams (mg) tablet by mouth twice a day for Dementia, Escitalopram oxalate 10 mg tablet by mouth once a day for Depression, Quetiapine 25 mg tablet by mouth at bedtime for Psychosis and to monitor for agitation every shift. Record review of a Progress Note written on 7/22/25 revealed Resident #1 sustained a fall in the patio area, reported pain in the left knee and right forearm, a physical assessment was performed and found on her left knee a bruise of about three centimeters (cm), and on the right arm a bruise of about one cm, the resident reported pain when bending the knee but she was able to walk, on a scale of 1 to 10 she reported that the pain was 4, and she was offered pain medication but she refused. Vitals signs were within normal limits, and the patient denied vomiting, or shortness of breath. No other positive findings were noted on the physical exam. Nurse Practitioner was called and new stat x rays order to perform right wrist, arm, and left knee received and carried out. The family was notified. Record review of the facility's Policy titled Identifying Types of Abuse Policy Statement: As part of the abuse prevention strategy, volunteers, employees and contractors hired by the facility are expected to be able to identify the different types of abuse that may occur against residents. During an interview on 7/28/25 at 10:18 AM, the Unit Manager, Registered Nurse (RN) stated: On 7/22/25, at approximately 4:00 PM while doing my rounds, a resident told me that [Resident #1] was physically abused by [Staff A, Mental Health Technician]. The resident described [Resident #1] was on the patio, placed a bag from a chair onto the floor and sat on the chair. At that time [Staff A, Mental Health Technician] pulled [Resident #1] out of the chair and [Resident #1] (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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER<br>REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0600</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>took an ash tray and threw it at [Staff A, Mental Health Technician]. Then [Staff A, Mental Health Technician] tried to block the ash tray by holding up the bag and pushed [Resident#1] with the bag and [Resident #1] fell on the floor. At that time [Staff A, Mental Health Technician] dragged [Resident#1] to the room. After hearing the details, I immediately reported it to The Administrator, and the cameras footage was viewed. I then I completed a full assessment on [Resident#1] on the patio and found a scrap on the Resident's right wrist and knee. There was no pain reported but the [Resident#1] was upset and was yelling. I comforted the resident at that time. On 7/28/25 at 1:57 PM The Social Services Director/ Abuse Coordinator revealed: On 7/22/25 it was reported to me by the Administrator that a nurse reported that a resident reported to her that [Staff A, Mental health technician] was aggressive towards another resident. The administrator looked at the cameras and verified that an incident occurred and instructed me to begin the federal report. I notified the police and Department of Children and Family (DCF). The police came and DCF came and investigated. We are completing the investigation today. During an interview regarding the allegations on 7/28/25 at 2:39 PM, Staff B, DCF investigator stated The investigation is ongoing. I spoke with [Staff A, Mental Health Technician] and discovered [Resident #1] was aggressive for the past five days and was attempting to break in the to get cigarettes and attacked [Staff A, Mental Health Technician]. I viewed video surveillance, and it showed [Staff A, Mental Health Technician] sitting on the patio and [Resident #1] threw backpack on the floor and [Staff A, Mental Health Technician] picked up the backpack then grabbed [Resident#1] and somehow the resident fell. Interview on 7/28/25 at 3:16 PM, with the Director of Nursing (DON) about the allegations; he stated: The unit manager reported to me on 7/22/25 around 4:00 PM that an abuse allegation was from another resident between [Staff A, Mental health technician] and Resident#1. From what I saw on the video, [Resident#1] went towards the smoking locker and grabbed a bag, threw it on the ground, and the [Staff A, Mental health technician] came from the non-smoking area and grabbed the resident's arm and snatched [Resident #1] off the chair where the resident was seated. Then [Resident#1] threw an ash tray towards [Staff A, Mental health technician] and started trying to hit [Staff A, Mental health technician]. [Staff A, Mental health technician] blocked the hits with the bag and [Resident #1] fell onto the floor in a sitting position. At that time, [Staff A, Mental health technician] pulled [Resident #1] from the ground and escorted the resident to the room. [Staff A, Mental health technician], did not report the incident. There were no other staff in the area. [Staff A, Mental health technician], was being rough and there was no need to .and it was completely unacceptable. A head-toe and pain assessment were done, and Medical Doctor and Psychiatrist were notified. The x-rays showed no fracture. The surveyor requested to view the video footage of the incident, but the DON revealed the footage had already been recorded over. Interview on 7/28/25 at 3:36 PM, the Administrator stated: An incident of physical abuse was reported to me by The Unit Manager. I reported it to the Abuse Coordinator. At that time, I viewed the camera footage, and I saw [Resident#1] throw [Staff A, Mental health technician bookbag] and sit on the chair. [Staff A, Mental health technician] grabbed [Resident #1] roughly by the arm and out the chair. [Resident#1] was then seen returning and charging and hitting [Staff A, Mental health technician]. [Staff A, Mental health technician] used the bookbag in defense and the bookbag touched [Resident#1] in the face and the resident fell on the floor, then got up and threw an ash tray at [Staff A, Mental health technician]. [Staff A, Mental health technician] then grabbed [Resident #1] by the arm and inside. I investigated this incident by reviewing the footage and interviewing other residents, family, and staff. We concluded that the allegation was verified, and the employee was terminated on 7/28/25. On 7/29/25 at 9:22 am The Social services Director/ Abuse Coordinator revealed the investigation was concluded and the allegation of physical was abuse verified.</p> |                                                                                       |                                                 |