

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105217	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2025
NAME OF PROVIDER OR SUPPLIER North Beach Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2201 NE 170th Street 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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51356</p> <p>Based on observation, interview and record review, the facility failed to ensure one (Resident # 398) out of three sampled residents devices was in place to alert staff in the event of an emergency as evidence by Resident 398's call light and phone were observed out of the resident's reach.</p> <p>The findings include:</p> <p>During observation on 01/06/25 at 08:30 AM Resident #398 was observed slouched over in bed eating breakfast. The resident's call light was noted hanging behind the bed and her telephone was observed on top of the overhead light.</p> <p>On 01/07/25 at 09:30 AM; Resident #398 was observed resting in bed and the call light was observed hanging behind the bed.</p> <p>Review of Resident # 398's medical records revealed the resident was admitted to the facility on [DATE]. Clinical diagnoses include Epilepsy, Unspecified, not intractable, and without status epilepticus.</p> <p>Review of the Physician's Orders Sheet for 11/04/2024 revealed Resident #398 orders include: Bedrails for positioning and or enabling, bedrail x 2 quarters.</p> <p>Review of Resident #398 's Significant Change Minimum Data Set (MDS) dated [DATE] revealed the resident is cognitively appropriate and require maximal assistance for care is required.</p> <p>Review of Resident # 398's Care Plans revealed the Resident has a self-care deficit with dressing, grooming, bathing, needs assistance with personal care tasks, mobility skills, impaired mobility and generalized weakness. Interventions include: Encourage/remind the resident to ask for assistance as needed and staff to anticipate resident's needs with activities of daily living (ADLs).</p> <p>During an interview on 01/09/25 at 12:42 PM Staff G, Licensed Practical Nurse (LPN) revealed the call light should be within reach of residents at all times and rounds should be done every two hours.</p> <p>Review of the facility's policies regarding call light indicates: to ensure that the call light is accessible to the resident when in bed, from the shower or bathing facility and from the floor.</p>

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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>48906</p> <p>Based on observations, record review, and interviews the facility failed to provide a safe environment for all residents, as evidenced by one out of three dryer lint traps in the laundry room observed full of lint. There were 94 residents residing in the facility at the time of survey.</p> <p>The findings included:</p> <p>On 01/09/25 at 8:51 AM a laundry tour was conducted with the Director of Housekeeping. Observation in the clean room revealed three dryers and one was not in progress. The dryer that was not in progress was noted with a large amount of lint. Review of a log posted on the wall revealed the lint traps are scheduled to be signed bi hourly after dryer lint traps are cleaned. There were two signatures missing and it was last signed at 9:00 PM on 1/8/24 (photographic evidence). Staff D, Housekeeping/laundry personnel revealed the lint trap had not been cleaned yet and explained the protocol and purpose for cleaning the dryers' lint traps I am responsible to clean lint trap hourly and then sign the lint log. I forgot to sign the log and didn't get a chance to clean the trap because I got busy. I am aware that it is a potential fire hazard.</p> <p>The facility does not have a policy for cleaning of the lint traps per the Director of Nursing.</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48906</p> <p>Based on record review and interviews facility failed to notify the Office of the Ombudsman about the transfer of five residents (#17, #16 #10, #24, #73) out of 23 residents sampled, as evidenced by reports of unsuccessful fax transmittals for The Notice of Transfer/Discharge Letter to The Office of The Ombudsman for December and November 2024. There were 94 residents residing in the facility at the time of survey.</p> <p>The findings included:</p> <p>1) Record review of a demographic sheet revealed Resident#17 was admitted on [DATE], hospitalized on [DATE] and readmitted on [DATE] with diagnosis that include: Chronic Obstructive Pulmonary Disease (COPD) and Acute Respiratory Failure with Hypoxia and Cough</p> <p>Record review of a narrative nurses note dated 11/21/2024 revealed Resident #17 was transferred from the facility via emergency services and admitted to a local hospital for Acute respiratory failure.</p> <p>Record review of the electronic health record revealed a signed Bed Hold policy dated 11/21/24.</p> <p>The fax notification sent to The Office of the Ombudsman for Resident #17's transfer to the hospital dated 11/26/24 revealed the line was busy.</p> <p>2) Record review of a demographic sheet revealed Resident #16 was admitted on [DATE] and had a hospital leave on 10/9/24.</p> <p>Record review of a Discharge return anticipated MDS with reference date of 10/9/24 Sections: A (identification) revealed Discharge was unplanned to a short-term general hospital.</p> <p>Record review of Resident #16's physician's order sheet revealed an order dated 10/10/24 to transfer the resident to nearby hospital for PEG (percutaneous endoscopic gastrostomy) tube placement.</p> <p>Record review of a Narrative Nurses note dated 10/9/2024 revealed Resident #16 was transferred to a nearby hospital for PEG placement.</p> <p>The fax confirmation of notification sent to the Office of the Ombudsman for Resident #16's transfer to the hospital dated 11/01/24 revealed the line was busy.</p> <p>Interview on 01/08/25 at 09:22 AM, the medical records personal stated: I am responsible for sending the Nursing Home Transfer and Discharge Notice to the office of the Ombudsman. I send it via fax. I send notices every other week. The fax confirmation does say busy, and I will get back to you with the answer.</p> <p>On 01/09/25 at 10:26 AM, the medical records staff revealed all transfer notices for November and December 2024 were not confirmed as received by the Ombudsman.</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>31581</p> <p>3) Record review of the Demographic Face Sheet for Resident #10 documented the resident was admitted on [DATE] with a diagnosis of Hemiplegia, emphysema and hypertension. The resident was discharged on [DATE] to the hospital.</p> <p>Review of the Physician's Orders Sheet (POS) dated 10/08/2024 for Resident #10 documented to send the resident to the local hospital.</p> <p>Review of the Ombudsman Nursing Home Transfer and Discharge Notice for Resident #10 documented the notice was sent with the resident to the hospital on 10/08/2024 with an effective date of 10/08/2024. The location to which the resident is to be transferred or discharged was a local hospital. Further review revealed the form was faxed with no response and the Ombudsman line was busy. The facility did not follow up with the Ombudsman.</p> <p>4) Record review of the Demographic Face Sheet for Resident #24 documented the resident was admitted on [DATE] with a diagnosis of diabetes mellitus, hypertensive heart disease and chronic obstructive pulmonary disease. The resident was discharged on [DATE] to the hospital.</p> <p>Review of the Physician's Orders Sheet (POS) dated 10/19/2024 for Resident #24 documented to send the resident to the local hospital.</p> <p>Review of the Ombudsman Nursing Home Transfer and Discharge Notice for Resident #24 documented the notice was sent with the resident to the hospital on 10/19/2024 with an effective date of 10/19/2024. The location to which the resident is to be transferred or discharged was a local hospital. Further review revealed the form was faxed with no response and the Ombudsman line was busy. The facility did not follow up with the Ombudsman.</p> <p>5) Record review of the Demographic Face Sheet for Resident #73 documented the resident was admitted on [DATE] with diagnosis that include parkinsonism. The resident was discharged on [DATE] to the hospital.</p> <p>Review of the Physician's Orders Sheet (POS) dated 11/02/2024 for Resident #73 documented to send the resident to the local hospital.</p> <p>Review of the Ombudsman Nursing Home Transfer and Discharge Notice for Resident #73 documented the notice was sent with the resident to the hospital on 11/02/2024 with an effective date of 11/02/2024. The location to which the resident is to be transferred or discharged was a local hospital. Further review revealed the form was faxed with no response and the Ombudsman line was busy. The facility did not follow up with the Ombudsman.</p> <p>Interview with the Director of Nursing (DON) on 1/09/25 at 9:33 AM. She stated, On 11/02/2024, the resident did not respond to the attention we give her. Assistance was given to the food but she did not respond with the swallowing. Food had to be unpack from her mouth. Nothing eaten from breakfast and lunch. MD was called made him aware and order to send resident to Aventura hospital for evaluation. Family and supervisor made aware. We have been calling the Ombudsman asking for an alternative number to send the faxes. We keep getting a busy signal. They told us we can't email it in. This has been going on for months.</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with Medical Records Staff on 1/09/25 at 11:11 AM. She stated, I emailed the Ombudsman forms on yesterday for November 2024 and December 2024 for patients discharged . Before that I would fax them monthly and would receive a busy signal. She confirmed that she did not follow up with the Ombudsman concerning an alternative way to send the transfer forms.</p> <p>Interview with the Ombudsman on 1/09/25 at 1:25 PM. She revealed that she had not been receiving the Ombudsman forms weekly nor monthly. She has given the contact information on where to send the Ombudsman forms and has informed the facility that they can email them. On yesterday, 1/08/25 she received the Ombudsman forms for the months of November 2024 and December 2024 via email.</p> <p>Review of a policy titled, Transfer or Discharge Notice (undated) revealed Policy Statement: Residents and/or representatives are notified in writing, and in a language and format they understand, at least thirty (30) days prior to a transfer or discharge. Policy Interpretation and Implementation 1. the name, address, email and telephone number of the entity which receives appeal hearing requests;1. The name, address, and telephone number of the Office of the State Long-term Care Ombudsman; A copy of the notice is sent to the Office of the State Long-Term Care Ombudsman at the same time the notice of transfer or discharge is provided to the resident and representative.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48906</p> <p>Based on interviews and record review facility failed to implement a nutritional care plan for one resident out of seven residents sampled (Resident #297) as evidenced by staff failed to notify the physician about an incident of aspiration reported by an alert and oriented resident. There were 94 residents residing in the facility at the time of survey.</p> <p>The findings included:</p> <p>Observation and interview on 01/06/25 at 10:03 AM. Resident#297 was in bed awake and alert in bed and a breakfast tray was noted at the bedside. Resident #297 was asked about the choking incident; Resident#297 stated: A chunk of food went too deep in my throat because I need to blend my food, but I cannot have a blender in the room because it's a fire hazard. When it happened, I was screaming and my roommate helped me by wrapping his arms around my belly and squeezing until the food popped out of my mouth. The nurse was present while my roommate was helping me but did not intervene.</p> <p>During an interview on 01/09/25 at 10:01 AM. Staff A, Licensed Practical Nurse (LPN) stated, I did not witness [Resident#297] choking. During the evening medication administration and while I was in the room, [Resident#297] told me, 'If it weren't for my roommate, I wouldn't be here because something got caught in my throat while I was eating.' At that time, I assessed [Resident#297], and [Resident # 297] reported being okay. I also offered to call [Resident#297's] daughter, but the Resident declined. I even asked [Roommate] if he knew the maneuver to help expel food if caught in someone's throat. [Roommate] told me he helped [Resident #297], and everything is fine. There was no documentation, and I did not call the physician. I should have documented and reported the incident to the physician. I continued to monitor [Resident #297] that day and over the weekend and no eating problems arose.</p> <p>Record review of Resident #297's demographic face sheet revealed an admitted [DATE] with diagnosis that included Abdominal Hernia without obstruction or gangrene.</p> <p>Review of a Care Plan initiated on 12/20/2024 revealed Resident #297 had the potential for nutritional problem related to comorbidities that included: abdominal hernia and diverticulum of bladder with a goal to maintain adequate nutritional status as by 03/17/2025. The interventions included: Observe for signs and symptoms of chewing/swallowing difficulties and aspiration; notify physician if noted.</p> <p>Record review of a December 2024 physician's orders sheet revealed Resident #297 was receiving a Gluten Free diet, regular texture and thin liquids.</p> <p>Record review of an Admission Minimum Data Set (MDS) referenced dated 12/22/24 indicated Resident # 297 is cognitively intact and needed set up and clean up assistance for eating and oral hygiene.</p> <p>On 01/09/25 at 3:24 PM, the Director of Nursing revealed she had no knowledge of any choking incident involving Resident #297 and stated: If a nurse is made aware of an incident it should be documented and reported to the physician.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of a policy titled, Care Plans, Comprehensive Person-Centered dated 2001 MED-PASS, Inc. (Revised March 2022) revealed A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation 3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. 8. Services provided for or arranged by the facility and outlined in the comprehensive care plan are: 1. provided by qualified persons.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48906</p> <p>Based on observations, interviews, and record reviews, the facility failed to provide quality of care for two residents (Resident #297 and Resident #398) out of twenty-three sampled residents, as evidenced by a Licensed Practical Nurse (LPN) failed to notify the physician and document an incident of food aspiration reported by Resident #297 and failure to position Resident# 398 appropriately during meals to prevent aspiration. There were 94 residents residing in the facility at the time of survey.</p> <p>The findings included:</p> <p>Resident #297</p> <p>Observation and interview on 01/06/25 at 10:03 AM. Resident#297 was in bed awake alert and oriented bed; a breakfast tray was noted at the bedside. When asked about the choking incident; Resident#297 stated: A chunk of food went too deep in my throat because I need to blend my food, but I cannot have a blender in the room because it's a fire hazard. When it happened, I was screaming and my roommate helped me by wrapping his arms around my belly and squeezing until the food popped out of my mouth. The nurse was present while my roommate was helping me but did not intervene. Resident#297 uncovered tray and an uneaten meat patty was noted on the plate.</p> <p>During an interview on 01/09/25 at 10:01 AM. Staff A, Licensed Practical Nurse (LPN) stated, I did not witness [Resident#297] choking. During the evening medication administration and while I was in the room, [Resident#297] told me, 'If it weren't for my roommate, I wouldn't be here because something got caught in my throat while I was eating.' At that time, I assessed [Resident#297], and [Resident # 297] reported being okay. I also offered to call [Resident#297's] daughter, but the Resident declined. I even asked [Roommate] if he knew the maneuver to help expel food if caught in someone's throat. [Roommate] told me he helped [Resident #297], and everything is fine. There was no documentation, and I did not call the physician. I should have documented and reported the incident to the physician. I continued to monitor [Resident #297] that day and over the weekend and no eating problems arose.</p> <p>Record review of Resident #297's demographic face sheet revealed an admitted [DATE] with diagnosis that included Abdominal Hernia without obstruction or gangrene.</p> <p>Review of a Care Plan initiated on 12/20/2024 revealed Resident #297 had the potential for nutritional problem related to comorbidities that included: abdominal hernia and diverticulum of bladder with a goal to maintain adequate nutritional status as by 03/17/2025. The interventions included: Observe for signs and symptoms of chewing/swallowing difficulties and aspiration; notify physician if noted.</p> <p>Record review of a December 2024 physician's orders sheet revealed Resident #297 was receiving a Gluten Free diet, regular texture and thin liquids.</p> <p>Record review of an Admission Minimum Data Set (MDS) referenced dated 12/22/24 indicated Resident # 297 is cognitively intact and needed set up and clean up assistance for eating and oral hygiene.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 01/09/25 at 3:24 PM, the Director of Nursing revealed she had no knowledge of any choking incident involving Resident #297 and stated: If a nurse is made aware of an incident it should be documented and reported to the physician.</p> <p>51356</p> <p>Resident# 398</p> <p>During observation on 01/06/2025 at 08:30 AM Resident #398 was observed slouched over in bed eating breakfast.</p> <p>During observation on 01/06/25 at 12:30 PM Resident #398 was observed in a reclined position while eating and drinking during lunch.</p> <p>Review of the medical records for Resident #398 revealed the resident was admitted to the facility on [DATE]. Clinical diagnoses included but not limited to: Epilepsy, Unspecified, not intractable, without status epilepticus.</p> <p>Review of the Physician's Orders Sheet for 11/04/2024 revealed Resident #398 had orders that included but not limited to: Bedrails for positioning and/or enabling, bedrail x 2 quarters</p> <p>Review of Resident #398 's Significant Change Minimum Data Set (MDS) dated [DATE] revealed Resident # 398 is cognitively intact and maximal assistance for care is required.</p> <p>Review of Resident # 398's Care Plans revealed the Resident has a self-care deficit with dressing, grooming, bathing related to (r/t): as evidenced by needs assistance with personal care tasks, mobility skills, impaired mobility and generalized weakness. Interventions include- Bedrails for positioning and/or enabling bedrail x 2 quarters and staff to anticipate resident's needs with activities of daily living (ADLs).</p> <p>Interview on 01/09/2025 at 12:34 PM; with Staff G, Licensed Practical Nurse (LPN) stated: If a resident is eating they should be sitting at least at a 45-to-90-degree angle; [Resident #398] normally eats in dining room or her room, she is an independent eater but needs help with setting up her tray and the CNAs (Certified Nursing Assistants) helps to position her in bed. Staff makes frequent rounds in room to prevent choking.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48906</p> <p>Based on observations, interviews and record reviews facility failed to provide adequate supervision to ensure an environment free of safety hazards for two residents (#9, #17) out of 23 sampled residents as evidenced by boxes of cigarettes and electrical cigarette at Resident #9's bedside and a shaving razor at Resident #17's bedside. There were 94 residents residing in the facility at the time of survey.</p> <p>The findings included:</p> <p>On 01/06/25 at 9:32 AM Resident #9 was observed in bed, the open nightstand drawer had two boxes of cigarettes inside. (photo submitted).</p> <p>On 01/06/25 at 9:35 AM, Staff A, Licensed Practical Nurse (LPN) was asked if residents are allowed to keep cigarettes in room. Staff A, LPN replied, No. During a side-by-side observation of the open drawer in Resident #9's room Staff A, LPN stated, I will check about the cigarettes. Staff A left the room and returned with the Director of Nursing (DON). The DON removed the two packs of cigarettes and educated Resident #9 that these items were not allowed.</p> <p>Record review of a demographic sheet for Resident#9 revealed an admitted [DATE] with diagnosis that included: Encounter for Surgical aftercare following surgery of the digestive system and Quadriplegia.</p> <p>On 01/08/25 at 11:08 AM while observing the smoking area, Staff F, Activities Aide revealed: All the smoking supplies are kept in a locked compartment which is kept at the front desk and only the receptionist and maintenance have a key. Staff F showed a compartment with boxes of smoking supplies, each box was labeled with residents' names. Staff F, Activities Aide further stated: I hand out the smoking supplies to the residents. The residents are not allowed to take any smoking supplies into their room. I ensure the residents return the lighter to me.</p> <p>During another observation on 01/08/25 at 1:27 PM, in Resident # 9's room, a box of cigarette and an electric cigarette were noted in an open drawer in Resident #9's room (photographic evidence). Resident #9 was asked about the understanding of the smoking policy, Resident #9 stated: I smoke in the patio, and I get my supplies from my friend and the staff keep it. The staff transported me to the patio to smoke. I am aware that I should not keep cigarettes in my drawer. The DON was informed of the cigarettes observed in the resident's room. The DON entered Resident #9's room and removed the electric cigarette and a box of cigarettes and reeducated Resident #9.</p> <p>On 01/08/25 at 1:45 PM Staff E, Certified Nursing Assistant (CNA) stated, I check [Resident#9's] drawers daily and inform the nurse if there are any smoking items inside. Every time the staff remove items, Resident#9 gets more. I always see the electric cigarette in the drawer and sometime in the bed and I have informed the nurse. Once I witnessed Resident #9 smoking the electric cigarette in his room and I informed the nurse.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER North Beach Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2201 NE 170th Street North Miami Beach, FL 33160	
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident#9's Quarterly Minimum Data Set (MDS) with a reference date of 12/20/24 indicate Resident # 9 is cognitively intact, required set up/clean up assistance for eating, supervision/ touching assistance for oral hygiene and dependent for transfer. Review of an Admission MDS reference dated 09/19/24 documented Yes for current tobacco use.</p> <p>Review of a Care Plan initiated on 09/16/2024 and revised on 11/13/2024 revealed Resident #9 desired to smoke, has been assessed as able to smoke with supervision. Resident or responsible party have been informed of the facility smoking policy and had a history of not being compliant with smoking policy with a goal to demonstrate safe smoking practices thru 12/25/2024. The interventions included: Maintain smoking materials in designated area.</p> <p>Review of the electronic health record of Resident #9 revealed a Smoking assessment dated [DATE] which indicated Resident #9 had the cognitive and physical ability to smoke safely and must request smoking materials from staff.</p> <p>Review of a policy titled, SMOKING POLICY-RESIDENTS effective date: 9/15/2022 revealed Policy: The Center will establish and maintain a safe designated smoking area and safe smoking practices for the residents. Smoking is only allowed in the designated outdoor areas of the facility and during designated times. Procedures: 4. Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. 7. The Center will retain and store all smoking materials, including matches, lighters, cigarettes, cigars, and any other smoking implement for all residents who wish to smoke. 11. Electronic cigarettes and vaping are permitted, but only in the facility designated smoking areas. 1. The same rules that apply to regular tobacco cigarettes also apply to electronic smoking and vaping materials. 2. Electronic cigarettes and vaping materials, including the liquids, will be retained and stored by nursing staff</p> <p>On 01/06/25 at 11:23 AM Resident #17 was observed in bed with oxygen in progress via nasal cannula. A shaving razor was observed inside a napkin box on the side table (photographic evidence). Staff A, LPN was notified and removed the shaving razor. Staff A, LPN revealed the Resident # 17's son brought the shaving razor.</p> <p>On 01/06/25 at 11:35 AM Staff C, CNA revealed Resident#17 was not given a shaving razor by the CNA and the shaving razor was not noticed during rounds or during hygiene care.</p> <p>Record review of a demographic sheet for Resident#17 revealed an admitted [DATE] readmission: 9/8/23 with diagnosis that included: Major Depressive Disorder.</p> <p>Review of a Discharge Return Anticipated MDS for Resident#17 reference dated 11/21/24 indicated Resident # 17's cognitive status is undetermined; required supervision/touching assistance for eating/oral hygiene and dependent for toileting/shower/bathe/transfer.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a Care Plan initiated on 06/28/2024 and revised on 09/27/2024 revealed Resident#17 had a self-care deficit and decreased mobility and requires set-up to supervision with eating and extensive to total assistance with the rest of Activities of Daily Living (ADL). Goal: Resident #17 will allow staff to assist with ADLs as deemed necessary for proper hygiene and safety thru 12/03/2024. Interventions included: Provide hands-on assistance with dressing, grooming, bathing as needed and staff to anticipate resident's needs with ADLs.</p> <p>Review of a Policy titled, Safety and Supervision of Residents 2001 MED-PASS, Inc. (Revised July 2017) revealed Policy Statement: Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Policy Interpretation and Implementation: Facility-Oriented Approach to Safety: 2. Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes; QAPI reviews of safety and incident/accident data; and a facility-wide commitment to safety at all levels of the organization. Individualized, Resident-Centered Approach to Safety. Implementing interventions to reduce accident risks and hazards shall include the following: 2. Resident supervision is a core component of the systems approach to safety.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>39177</p> <p>Based on observation, interview and record review, the facility failed to ensure drugs and biologicals used in the facility are stored properly; as evidenced by observation revealed discontinued medication observed on Medication Cart, medications left unattended, staff placed insulin in pocket, undated open sterile water for inhalation in medication room, staff's personal items noted on counter in Medication Room and medications observed at bedside.</p> <p>Observation on 01/06/25 at 08:59 AM of South Medication Cart #1 with Staff I, Licensed Practical Nurse (LPN), discontinued medication Difidic (fidaxomicin) 200 mg (milligrams) for Resident #92 was noted in the top drawer of the cart.</p> <p>Review of order written on 12/13/24 documented: Give 200 mg by mouth two times a day for C-Diff until 12/24/24.</p> <p>Review of the Medication Administration Record (MAR) revealed the medication was administered from 12/14/24 to 12/24/24.</p> <p>Interview on 01/06/2025 at 08:59 AM Staff I, LPN (Licensed Practical Nurse revealed the resident started receiving the medication on 12/14/24 and of the South Cart on 01/06/25 at 08:59 AM with Staff I, LPN (Licensed Practical Nurse)</p> <p>Interview on 01/06/25 at 9:16 AM Staff I, LPN acknowledged the Difidic (fidaxomicin) 200 mg (milligrams) for Resident#92 was discontinued and should not have been on the cart. Staff I, LPN revealed all nurses are responsible for checking their cart for discontinued and expired medications. The night supervisor collects the expired and discontinued medications for them to be returned to the pharmacy.</p> <p>During an interview on 01/09/25 at 03:25 PM, the Director Of Nursing (DON) stated: The nurses should be checking the cart before and after the shift; the last nurse that gave the medication should have removed the medication.</p> <p>On 01/06/2024 at 10:00 AM, during medication administration observation with Staff J, Registered Nurse (RN) on the North Wing's Cart 2. Staff J, RN prepared medications that included 30 ml (milliliters) liquid supplement for Resident #64. Staff J, RN proceeded to administer the liquid supplement that was in a medication cup but the refused it; Staff J, RN placed the cup containing the supplement on the tray with the medication cup with pills and the liquid supplement spilled in the medication cup that had the pills. Before exiting the room, Staff J, RN explained to the resident that she needed to discard the pills and return with new pills.</p> <p>Upon returning to the medication cart Staff J revealed there was no drug disposal system in the cart, and she will check in the med room.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 01/06/25 at 10:14 AM, Staff J went to find a drug disposal system in the room located on the north wing behind the nurses station but did not find the drug disposal system. Staff J, RN revealed they will need to get the drug disposal container in the DON's office. Staff J went to get it; Staff J and RN exited the medication room leaving the door open and the unattended on the counter. Staff J returned three minutes later with a large drug disposal system container and dispose of the medications.</p> <p>Interview on 01/06/25 at 10:18 AM, Staff J, RN revealed she is aware the medications should not be left unattended and stated: I thought it was ok because you (surveyor) were there.</p> <p>Upon further observation, Staff J, RN was asked about the items on the counter that included lunch bags/container and the two refrigerators. Staff J, RN revealed the lunch boxes belonged to staff, and the lower locked refrigerator is for insulins and the top refrigerator is for residents' food from family. Both refrigerators were inspected and the upper refrigerator that stored residents' food temperature was noted at 50 degrees Fahrenheit; there were undated labeled grocery store type plastic bags that had resident's names.</p> <p>On 01/06/25 at 11:05AM during an observation of the South Med Room with Staff H, LPN, an undated open bottle with Sterile water for inhalation in plastic bag and an Oxygen Humidifier bottle with water in a plastic bag was noted on the top shelf in the Med Room.</p> <p>On 01/06/25 at 11: 25 AM Staff H, LPN revealed the bottles should have been dated when they opened and needed to be removed; all nurses are responsible for checking the medication rooms.</p> <p>Observation on 01/06/25 at 11:46 AM, Staff J, RN completed Resident #51's blood glucose check and revealed resident needed insulin was not available on the cart.</p> <p>On 01/06/25 at 12:05 PM, Staff J, RN went to the medication room and retrieved the insulin from the refrigerator. Staff J explained the insulin is cold so she will need to wait for the medication to get warm. Staff J placed the insulin in her pocket and went to assist with passing meal trays.</p> <p>On 01/06/25 at 12:15 PM, Staff J, RN removed the insulin from her pocket and placed it in the top drawer of the cart.</p> <p>During an interview on 01/06/24 at 12/24/2024 Staff J, RN revealed she was not aware the insulin should not be placed in her pocket.</p> <p>Interview on 01/09/24 at 3:18 PM the DON revealed the nurse reported the concerns medications should never be left unattended, and the nurse should not have placed the insulin in her pocket for infection control reasons. Regarding the lunch boxes in the room, the DON indicated staff should not leave lunch boxes/personal items in that room because there is a break room for staff.</p> <p>48906</p> <p>Observation on 01/06/25 at 09:32 AM Resident #9 was in bed with eyes closed, a medicine cup with a small pink pill was noted on the bed next to Resident #9 (photo evidence). Resident #9's nightstand drawer was open, and a bottle labeled Vitamin C was observed inside (see photo evidence).</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 01/06/25 at approximately 9:38 AM, Staff A, Licensed Practical Nurse (LPN) stated: I did not give [Resident#9] any medication. No medications can be kept in the residents' rooms without staff present. Staff A, LPN entered the resident's room with the surveyor and removed cup with the pink pill and disposed of it in the puncture resistant container in the medication cart. Staff A, LPN returned with the Director of Nursing (DON) and the DON removed the bottle labeled Vitamin C and educated Resident #9.</p> <p>Observation and interviews on 01/06/25 at 11:23 AM Resident #17 was awake, alert, oriented, two inhalers were observed inside a tissue box on Resident #17's side table (photo taken). Staff A, Licensed Practical Nurse (LPN) was made aware and removed the item and reeducated resident. Resident# 17 revealed a family member brought in the inhalers.</p> <p>Record review of a Policy titled, Medication Labeling and Storage (undated) revealed the facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys. Policy Interpretation and Implementation: Medication Storage: 1. Medications are stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Each resident's medications are assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medications of several residents.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>31581</p> <p>Based on observation, interview and record review, the facility failed to store food under sanitary condition by ensuring 1) the resident's foods were dated, the refrigerator was working properly and 2) there was no thermometer in the refrigerator in the snack/nourishment refrigerator on the resident's unit. This has the potential to affect 89 out of 94 residents who eat orally residing in the facility at the time of the survey and the potential to affect 55 out of 57 residents who eat orally residing on the North Wing and affect 34 out of 36 residents who eat orally residing on the South Wing.</p> <p>The findings included:</p> <p>Record review of the Foods Brought by Family/Visitors Policy and Procedure (revision date March 2022); Policy Statement-Food brought to the facility by visitors and family is permitted. Facility staff will strive to balance resident choice and a homelike environment with the nutritional and safety needs of residents; Policy Interpretation and Implementation-5b) Containers are labeled with the resident's name, the item and the use by date.</p> <p>Review of the Refrigerators and Freezers Policy and Procedure (revision date December 2014); Policy Statement-This facility will ensure safe refrigerator and freezer maintenance, temperatures and sanitation and will observe food expiration guidelines; Policy Interpretation and Implementation-1) Acceptable temperature ranges are 35 degrees Fahrenheit (F) to 40 degrees F and less than 0 degrees F; 2) Monthly tracking sheets for all refrigerators and freezers will be posted to record temperatures; 3) Monthly tracking sheets will include time, temperature, initials and action taken and 4) All food shall be appropriately dated to ensure proper rotation by expiration dates.</p> <p>Observation of the North Wing Nourishment Pantry with the Long Term Care Supervisor on 1/06/25 at 10:19 AM revealed the refrigerator was 50 degrees F (Fahrenheit). The refrigerator had three plastic bags which contained resident's foods that were labeled but not dated. Photographic evidence submitted.</p> <p>Observation of the South Wing Nourishment Pantry on 01/06/25 10:23 AM revealed the refrigerator did not contain a thermometer. The refrigerator contained resident's foods dated and labeled. Photographic evidence submitted.</p> <p>Observation and interview with Staff A, Licensed Practical Nurse (LPN) South Wing Nurse on 1/06/25 at 10:24 AM of the South Wing Nourishment Pantry Refrigerator. She stated, Everything should be dated and there is no thermometer in the refrigerator.</p> <p>Interview with the Director of Nursing (DON) on 1/09/25 at 9:43 AM. She confirmed there should be a thermometer in the pantry refrigerator, the temperature in the refrigerator should be 40 degrees F and below and resident's food in the pantry refrigerators should be dated.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of the North Wing Daily Freezer/Refrigerator/Cooler/Reach In/Nourishment Temperature Log for January 2025 documented on 1/06/25 at 1:00 AM, the refrigerator temperature was 40 degrees F and on the South Wing Daily Freezer/Refrigerator/Cooler/Reach In/Nourishment Temperature Log for January 2025 documented on 1/06/25 at 6:00 AM, the refrigerator temperature was 38 degrees F.</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>42532</p> <p>Based on interview and record review, the facility failed to demonstrate effective plan of actions were implemented to correctly identify quality deficiencies in the problem area related to repeated deficient practices for F558 Reasonable Accommodations Needs/Preferences, F761 Label/Store Drugs and Biologicals, F880 Infection Prevention & Control, These deficient practices have the potential to affect 94 residents residing in the facility at the time of the survey.</p> <p>The findings included:</p> <p>Review of the facility's survey history revealed, during a recertification survey with exit dated August 31, 2023, F558 Reasonable Accommodations Needs/Preferences was cited related to the facility failure to ensure reasonable accommodations related call lights. F761 Label/Store Drugs and Biologicals, F880 Infection Prevention & Control.</p> <p>Interview with Administrator on 01/09/2025 at 4:00 PM. He revealed the QAPI (Quality Assurance and Performance Improvement) meetings are held on the second Tuesday of each month or as needed. He stated that QAPI committee members are Administrator, Director of Nursing, Assistant Director of Nursing, Medical Records, MDS Coordinator, Staff Coordinator, Activities Director, Social Services Director, Rehabilitation Director, Admission Director, Maintenance Director, Housekeeping Director, Dietary Manager, Medical Director, Human Resources Director, Corporate Officer. During the morning meetings and clinical meetings, they reviewed the last meeting and focused on the deficiencies the facility had for the last survey. Quality Assurance is continuously monitored and communicated with the department heads and tracked to ensure the correct actions implemented.</p> <p>Record review of Quality Assurance/Quality Assurance Performance Improvement QAPI/QAA Goals/Purpose Statement: Our purpose is to provide excellent quality resident/patient care and services. Quality is defined as meeting or exceeding the needs, expectations and requirements of the patients cost-effectively while maintaining good resident/patient outcomes and perceptions of patient care. NBRC has a Performance Improvement Program which systematically monitors, analyses and improves its performance to improve resident/ patient outcomes. It recognizes that the value in healthcare is the appropriate balance between good measures, excellent care and services and cost. We will monitor our operations for compliance with federal and state regulations.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>48906</p> <p>Based on observations, record review, and interviews the facility failed to follow infection prevention and control practices with one out of two vital signs machines in the facility and one out of three dryer lint traps in the laundry room, as evidenced by staff member not disinfecting the vital signs machine after measuring a resident's blood pressure and Clean laundry (curtains) stored in washing area.</p> <p>The findings included:</p> <p>1) On 01/06/25 at 8:03 AM Staff A, Licensed Practical Nurse (LPN) was observed measuring a resident's blood pressure using a vital sign machine. Afterwards, Staff A, LPN placed the used vital sign machine in the hallway near the nursing station. Staff A, LPN then returned to administering medications. Staff A, LPN did not disinfect machine or cuff and no sanitizing wipes were observed in the vital signs machine's basket.</p> <p>On 01/06/25 at 9:32 AM Staff A, LPN was asked about the protocol after using the blood pressure machine on a resident, Staff A, LPN stated: The protocol is to disinfectant with the Sanitizing cloths. I was supposed to clean the machine but forgot.</p> <p>Record review of a Policy titled, Infection Control Guidelines for All Nursing 2005 MED-PASS, Inc. (Revised August 2012) Purpose: To provide guidelines for general infection control while caring for residents. 1. Standard Precautions will be used in the care of all residents in all situations regardless of suspected or confirmed presence of infectious diseases. Standard Precautions apply to blood, body fluids, secretions, and excretions regardless of whether they contain visible blood, non-intact skin, and/or mucous membranes.</p> <p>On 01/09/25 at 12:09 PM, interview with the Infection Preventionist revealed there are two vital signs machines in the facility. Staff are responsible to disinfect the vital signs machines with disinfectant wipes after usage to prevent any cross contamination or break outs throughout the facility. Also revealed there are two vital signs machines.</p> <p>On 01/09/25 at 8:51 AM a Laundry Tour was conducted with The Director of Housekeeping. Upon entrance to the wash area there was a cart partially covered with linens in a plastic bag (photo submitted) The Director of Housekeeping revealed the plastic bag contained clean curtains that were being stored in the wash area for purposes of space.</p> <p>Record review of a Policy titled, Departmental (Environmental Services) Infection Control Departmental (Environmental Services) Laundry and Linen revealed Level I: Purpose: The purpose of this procedure is to provide a process for the safe and aseptic handling, washing, and storage of linen. General Guidelines: Standard Precautions 1. Separate soiled and clean linen always.</p>		