STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105252	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jackson Memorial Perdue Medical Center	19590 Old Cutler Road Cutler Bay, FL 33157

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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42532 Based on record review and interview, the facility failed to accurately code the Minimum Data Set (MDS) for one (Resident #158) out of 31 residents reviewed for resident assessments. As evidenced by inaccurate coding of MDS section for Discharge Status for Resident #158. The facility census was 154 residents at the time of the survey. The findings included: Record review of Resident #158's Discharge Return Not Anticipated Minimum Data Set (MDS) dated [DATE] Section for Identification Information in subsection for Discharge Status documented that the resident was discharged to an Acute Hospital. Review of the Physician's Orders Sheet for July 2024 revealed Resident #158 had orders that included but not limited to: Discharge to ALF (Assisted Living Facility), once until 07/24/2024. Review of nurses' progress notes for Resident #158 documented on 07/24/2024 timestamped 12:40: Resident d/c (discharged) to ALF at 1240 via transport. Resident left via transport. Resident left with w/c, (wheelchair). 0900 all medications administered by assigned nurse prior to discharge. Medication education provided and all upcoming appointments reviewed with resident and verbalized understanding. All safety and comfort measures in place. Further review of the medical records for Resident #158 revealed the resident was admitted to the facility on [DATE]. Clinical diagnoses included but not limited to: Atrial Fibrillation. Resident #158 was discharged on [DATE]. Record review of Resident #158's Care Plan dated 04/29/2024 revealed: Resident's Short Term Discharge Plan: The plan for resident is to be discharged back to ALF. Interventions included: The goal for the resident is to have all needs met related to discharge planning and staff to assist and coordinate with the resident as needed for a safe discharge. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105252	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER Jackson Memorial Perdue Medical Center		STREET ADDRESS, CITY, STATE, ZIP CODE 19590 Old Cutler Road Cutler Bay, FL 33157	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/24/2024 at 10:02 AM, during an interview with Registered Nurse, Minimum Data Set Coordinator (Staff E), the surveyor had Staff E check the nurses progress notes documented on 07/24/2024 that noted the resident was discharged to ALF and check the Discharge Minimum Data Set with reference dated 07/24/2024, Section A that documented that the resident was discharged to an acute hospital. Staff E acknowledged the discrepancy. Staff E stated, We get the information from Social Services, and it is also discussed in the morning meeting. Social Services also makes a note to where the resident is being discharged to. The coding of 04 was entered and should be 01. According to the note, resident was discharged to ALF. Review of the facility's policy and procedures titled Nursing Care: MDS - 3.0 Resident Assessment Instrument dated 01/10/2023 states: Purpose - The MDS is used to provide a holistic assessment of each resident to promote optimum quality of care and quality of life. It is also used to identify resident care problems that are addressed in an individualized resident centered care plan, as for Medicare reimbursement. It is imperative that all sections are accurately coded by each discipline.

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	105252	A. Building B. Wing	10/24/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51065 Based on record review and interview, the facility failed to accurately code the Minimum Data Set (MDS) for one (Resident #158) out of 31 residents reviewed for resident assessments. As evidenced by inaccurate coding of MDS section for Discharge Status for Resident #158. The facility census was 154 residents at the time of the survey. The findings included: Review of the medical records for Resident #158 revealed the resident was admitted to the facility on [DATE]. Clinical diagnoses included but not limited to: Atrial Fibrillation. Resident #158 was discharged on [DATE]. Record review of Resident #158's Discharge Return Not Anticipated Minimum Data Set (MDS) dated [DATE] Section for Identification Information in subsection for Discharge Status documented that the resident was discharged to an Acute Hospital. Review of the Physician's Orders Sheet for July 2024 revealed Resident #158 had orders that included but not limited to: Discharge to ALF (Assisted Living Facility), once until 07/24/2024. Review of nurses' progress notes for Resident #158 documented on 07/24/2024 timestamped 12:40: Resident d/c (discharged) to ALF at 1240 via transport. Resident left via transport. Resident left with w/c, (wheelchair). 0900 all medications administered by assigned nurse prior to discharge. Medication education provided and all upcoming appointments reviewed with resident and verbalized understanding. All safety and comfort measures in place. Record review of Resident #158's Care Plan dated 04/29/2024 revealed: Resident's Short Term Discharge Plan: The plan for resident is to be discharged back to ALF. Interventions included: The goal for the resident is to have all needs met related to discharge planning and staff to assist and coordinate with the resident as needed for a safe discharge. On 10/24/2024 at 10:02 AM, during an interview with Registered Nurse, Minimum Data Set Coordinator (Staff E), the surveyor had Staff E check the nurses progress notes documented on 07/24/2024 that noted the resident was discharged to ALF and check the Discharge Minimum Data Set with reference dated 07/24/2024, Section A that documented that the resident was discharged to an acute hospital. Staff E acknowledged the discrepancy. Staff E stated, We get the information from Social Services, and it is also discussed in the morning meeting. Social Services also makes a note to where the resident is being discharged to. The coding of 04 was entered and should be 01. According to the note, resident was discharged to ALF. Review of the facility's policy and procedures titled Nursing Care: MDS - 3.0 Resident Assessment Instrument dated 01/10/2023 states: Purpose - The MDS is used to provide a holistic assessment of each resident to promote optimum quality of care and quality of life. It is also used to identify resident care problems that are addressed in an individualized resident centered care plan, as for Medicare reimbursement. It is imperative that all sections are accurately coded by each discipline.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 45019 Based on observation, interview and record review the facility failed to implement care plan interventions related to falls for two out of four residents reviewed (Resident #78 and Resident #151). As evidenced by, during several observations Resident #78 and #151 were in bed with only one fall mat on the floor of each resident's bedside. The findings Included: 1) Observation on 10/22/24 at 10:00 AM; Resident #78 was asleep in bed, one floor mat noted on floor next to the bed's right side. Observation on 10/23/24 at 08:02 AM; Resident #78 was asleep in bed, breakfast tray on overbed table, one floor mat noted on floor next to the bed's right side. Review of Resident #78's medical records revealed the resident was admitted to the facility on [DATE]. Clinical diagnoses included but not limited to: Essential (primary) hypertension and Unspecified dementia with behavioral disturbance. Review of Resident #78's Physician Order Sheets for October 2024 revealed orders that included but not limited to: Low bed and Bilateral floor mats when resident in bed every shift, morning, evening and night. Record review of Resident #78 's Care Plans Reference Date 06/30/23 revealed: Resident #78 has a Potential for Falls related to: Decreased functional mobility Decreased Activities of Daily Life functions: Resident has poor safety awareness. Resident is at risk for falls. On 10/26/21 the resident was found on kneeling position. The resident stated that he was attempting to walk to the bathroom. No apparent injuries noted. Denied pain. On 11/07/21 the resident was found sitting on the floor in front of his wheelchair; No apparent injury noted related to this fall. Provider notified. 02/14/22 resident was observed sitting on floor mat next to his bed. No apparent injury noted related to this fall. Provider aware; no new orders. 03/28/23 fall with orders for transfer to local hospital for further evaluation/treatment and management to rule out fracture and/or deformity. 06/30/23 resident was found on the floor, no apparent injury noted related to this fall. Primary provider and guardian were notified. New order carried out. 7/9/23: Resident found sitting on the floor during shift change, bed was in lowest position. Assessment done no injuries noted, denied pain or discomfort, Certified Nursing Assistant (CNAs) ordered to make hourly rounds. Bed kept in lowest position; resident educated to use call light for assistance. 02/09/24 Resident was found sitting on the floor status post fall from wheelchair, denied pain/discomfort. Physician (MD) notified, no new order. 08/01/24: Resident was found lying on the floor on his right side. The resident stated he crawled from his bed to the front door. He is able to move all extremities. No changes noted in his level of consciousness. Education provided on safety and the use of call lights for assistance. Resident acknowledged teachings; however, resident has poor safety awareness and poor insight into his limitations. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0656

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Goal included: Resident will be free from injurious falls through next review date. Resident will minimize fall incident through the next review date. Resident will maintain safety and will be free from related complications of fall through the next review date. Resident will be assessed with potential strategies and reevaluated based on needs to decrease potential harm secondary to fall through next review date.

Interventions included: Keep bed at lowest level at night or when resident is in bed. 02/17/22 Maintain on Low bed and place bilateral floor mats while in bed for safety as resident presents high risk for falls as ordered. Maintain fall and safety precautions at all times. 10/26/21 Educate, review safety precautions and risks of fall, related injuries including physical limitations for safety. Educate to call for assistance at all times. Ensure that assistance is available at all times .Place mats on floor for safety. 02/14/22 Keep resident on close supervision for safety. Continue with more physical rounding on shift for safety and check for incontinence. Continue to re-educate physical limitations for safety and encourage/remind to call for assistance at all times for safety. 08/01/24: Remind and educate safety precautions, risks of falls and physical limitations. Encourage to use call light and ask staff for

Review of Resident #78's Physician Order Sheets for October 2024 revealed orders that included but not limited to: Low bed and Bilateral floor mats when resident in bed every shift, morning, evening and night.

Review of Resident # 78's Quarterly Minimum Data Set (MDS) dated [DATE] documented in the section for Cognitive Patterns, a Brief Interview for Mental Status (BIMS) score of 5 out of 15 which indicates severe cognitive impairment. The Section for Behaviors indicated no behaviors exhibited. The Section for Functional Status documented the resident is dependent for care and the section for restraints documented no restraints or alarms used.

2) Observation on 10/21/24 at 09:34 AM; Resident #151 was asleep in bed, one floor mat noted on floor next to the bed's left side.

On 10/22/24 at 09:50 AM; Resident #151 in asleep in bed, one floor mat in place on the left next to the bed.

Review of Resident #151's medical records revealed the resident was admitted to the facility on [DATE]. Clinical diagnoses included but not limited to: Traumatic Subdural hemorrhage with loss of consciousness status unknown, subsequent encounter. Other fracture of lower end of right tibia, subsequent encounter for closed fracture with routine healing.

Review of Resident #151's Physician's Orders Sheet for October 2024 revealed orders that included but not limited to: Low bed and bilateral floor mats while resident in bed, patient at high risk for fall.

Record review of Resident # 151's Care Plans Reference Dated 11/05/23 revealed: Resident has a Potential for Falls related to: Decreased functional mobility Decreased activities of daily life functions: Resident has poor safety awareness.

Goals: Resident will be free from injurious falls through next review date. Resident will minimize fall incident through the next review date.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interventions include maintaining fall and safety precautions at all times. 09/15/24 Maintain on low bed with bilateral floor mats while resident in bed as ordered as resident presents high risks for falls. Review of Resident # 151's Admission Minimum Data Set (MDS) dated [DATE] documented in the section for Cognitive Patterns; a Brief Interview for Mental Status score of 7 out of 15 which indicates severe cognitive impairment. The section for Functional Status documented the resident is dependent for care. The section for medications documented the resident is taking Anticoagulant medications and the section for Restraints documented no restraints or alarms used. During an interview on 10/23/24 at 12:59 PM; Certified Nursing Assistant (CNA) (Staff F) South Wing revealed, during shift meetings staff are told what patients require fall mats. When we make rounds in the morning we check to make sure the residents have their mats while they are in bed, if a resident's floor mat is missing we first look under the bed because we remove the floor mats when providing care and place them under the bed, if the floor mats are not under the bed, we report it to the nurse, the nurse then calls housekeeping to get a replacement mat. Interview on 10/23/24 at 01:05 PM; Certified Nursing Assistant (CNA) (Staff G) South Wing stated: During my rounds I check to make sure my residents who are assigned floor mats have their floor mats and their bed are in the lowest position when they are in bed. If a resident's floor mats are missing, we first look under the bed because we remove the floor mats when providing care and place them under the bed. If the floor mats are not under the bed, we report it to the nurse, the nurse then calls housekeeping to get a replacement mat. Interview on 10/23/24 at 01:14 PM; Registered Nurse (RN) (Staff H) South Wings revealed: Residents are assessed for floor mats and orders are placed in the electronic system for each resident. During shift reports we discuss what resident has what type of orders. During my rounds I check to make sure the residents have their floor mats, if a resident's floor mat is missing, I notify my supervisor and ensure we get a replacement. Interview on 10/23/24 at 01:20 PM; South Wing Registered Nurse (RN) (Staff I) stated: During rounds I check on my residents and check to make sure their floor mats are in place, if the floor mats are missing, I would call the maintenance department and request they bring floor mats for the resident and notify my supervisor. Interview on 10/24/24 at 09:54 AM; the Director of Nursing/Risk Manager stated: All residents get reviewed upon admission and quarterly for falls, when they are at high risk for falls, they are given orders for floor mats, the nurses have access to the orders, the CNAs receive the information from their shift reports. During rounds all nursing staff should be checking the residents to make sure they have their floor mats when the residents are in bed. Review of the facility policy and procedure titled Interdisciplinary Care Planning revision date 10/09/24 indicated: Purpose: To assure that each resident is the recipient of an individualized, interdisciplinary, holistic and therapeutic approach to his/her problems/need.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - 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** 45019 Based on observation, interview, and record review the facility failed to ensure safety measures were implemented for two vulnerable residents (Resident #78 and Resident #151) out of four residents reviewed for falls. As evidenced by, during several observations Resident #78 and Resident #151 were observed in bed with only one floor mat (fall mats) on the floor of the residents' bedside. The findings Included: 1) Observation on 10/22/24 at 10:00 AM; Resident #78 was asleep in bed, one floor mat noted on floor next to the bed's right side. Observation on 10/23/24 at 08:02 AM; Resident #78 was asleep in bed, breakfast tray on overbed table, one floor mat noted on floor next to the bed's right side. Review of Resident #78's medical records revealed the resident was admitted to the facility on [DATE]. Clinical diagnoses included but not limited to: Essential (primary) hypertension and Unspecified dementia with behavioral disturbance. Review of Resident #78's Physician Order Sheets for October 2024 revealed orders that included but not limited to: Low bed and Bilateral floor mats when resident in bed every shift, morning, evening and night. Review of Resident # 78's Quarterly Minimum Data Set (MDS) dated [DATE] documented in the section for Cognitive Patterns, a Brief Interview for Mental Status (BIMS) score of 5 out of 15 which indicates severe cognitive impairment. The Section for Behaviors indicated no behaviors exhibited. The Section for Functional Status documented the resident is dependent for care and the section for restraints documented no restraints or alarms used. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #78 's Care Plans Reference Date 06/30/23 revealed: Resident #78 has a Potential for falls related to: Decreased functional mobility Decreased Activities of Daily Life functions: Resident has poor safety awareness. Resident is at risk for falls. On 10/26/21 the resident was found on kneeling position. The resident stated that he was attempting to walk to the bathroom. No apparent injuries noted. Denied pain. On 11/07/21 the resident was found sitting on the floor in front of his wheelchair; No apparent injury noted related to this fall. Provider notified. 02/14/22 resident was observed sitting on floor mat next to his bed. No apparent injury noted related to this fall. Provider aware; no new orders. 03/28/23 fall with orders for transfer to local hospital for further evaluation/treatment and management to rule out fracture and/or deformity. 06/30/23 resident was found on the floor, no apparent injury noted related to this fall. Primary provider and guardian were notified . 7/9/23: Resident found sitting on the floor during shift change . Assessment done no injuries noted .Certified Nursing Assistant (CNA) ordered to make hourly rounds. Bed kept in lowest position; resident educated to use call light for assistance. 02/09/24 Resident was found sitting on the floor status post fall from wheelchair, denied pain/discomfort. Physician (MD) notified, no new order. 08/01/24: Resident was found lying on the floor on his right side. The resident stated he crawled from his bed to the front door. He is able to move all extremities. No changes noted in his level of consciousness. Education provided on safety and the use of call lights for assistance. Resident acknowledged teachings; however, resident has poor safety awareness and poor insight into his limitations. Goal included: Resident will be free from injurious falls through next review date. Resident will minimize fall incident through the next review date. Resident will maintain safety and will be free from related complications of fall through the next review date. Resident will be assessed with potential strategies and reevaluated based on needs to decrease potential harm secondary to fall through next review date. Interventions included: Keep bed at lowest level at night or when resident is in bed. 02/17/22: Maintain on Low bed and place bilateral floor mats while in bed for safety as resident presents high risk for falls as ordered. Maintain fall and safety precautions at all times. 10/26/2: Educate, review safety precautions and risks of fall, related injuries including physical limitations for safety .Place mats on floor for safety. 2) Observation on 10/21/24 at 09:34 AM; Resident #151 was asleep in bed, one floor mat noted on floor next to the bed's left side. On 10/22/24 at 09:50 AM; Resident #151 was observed in bed asleep, one floor mat in place on floor at left side next to the bed. Review of Resident #151's medical records revealed the resident was admitted to the facility on [DATE]. Clinical diagnoses included but not limited to: Traumatic Subdural hemorrhage with loss of consciousness status unknown, subsequent encounter. Other fracture of lower end of right tibia, subsequent encounter for closed fracture with routine healing. Review of Resident #151's Physician's Orders Sheet for October 2024 revealed orders that included but not limited to: Low bed and bilateral floor mats while resident in bed, patient at high risk for fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident # 151's Care Plans Reference Dated 11/05/23 indicated the resident has a potential for falls related to decreased functional mobility, decreased activities of daily life functions and poor safety awareness. Goals included: Resident will be free from injurious falls through next review date. Resident will minimize fall incident through the next review date. Interventions included: maintaining fall and safety precautions at all times. 09/15/24- maintain on low bed with bilateral floor mats while resident in bed as ordered as resident presents high risks for falls. Record review of Resident # 151's Admission Minimum Data Set (MDS) dated [DATE]/24 documented in the section for Cognitive Patterns; a Brief Interview for Mental Status score of 7 out of 15 which indicates severe cognitive impairment. The section for Functional Status documented the resident is dependent for care. The section for medications documented the resident is taking Anticoagulant medications and the section for Restraints documented no restraints or alarms used. During an interview on 10/23/24 at 12:59 PM; Certified Nursing Assistant (CNA) (Staff F) South Wing revealed, during shift meetings staff are told what patients require fall mats. When we make rounds in the morning we check to make sure the residents have their mats while they are in bed, if a resident's floor mat is missing we first look under the bed because we remove the floor mats when providing care and place them under the bed, if the floor mats are not under the bed, we report it to the nurse, the nurse then calls housekeeping to get a replacement mat. Interview on 10/23/24 at 01:05 PM; Certified Nursing Assistant (CNA) (Staff G) South Wing stated: During my rounds I check to make sure my residents who are assigned floor mats have their floor mats and their bed are in the lowest position when they are in bed. If a resident's floor mats are missing, we first look under the bed because we remove the floor mats when providing care and place them under the bed. If the floor mats are not under the bed, we report it to the nurse, the nurse then calls housekeeping to get a replacement mat. Interview on 10/23/24 at 01:14 PM; Registered Nurse (RN) (Staff H) South Wings revealed: Residents are assessed for floor mats and orders are placed in the electronic system for each resident. During shift reports we discuss what resident has what type of orders. During my rounds I check to make sure the residents have their floor mats, if a resident's floor mat is missing, I notify my supervisor and ensure we get a replacement. Interview on 10/23/24 at 01:20 PM; South Wing Registered Nurse (RN) (Staff I) stated: During rounds I check on my residents and check to make sure their floor mats are in place, if the floor mats are missing, I would call the maintenance department and request they bring floor mats for the resident and notify my supervisor. Interview on 10/24/24 at 09:54 AM; the Director of Nursing/Risk Manager stated: All residents get reviewed upon admission and quarterly for falls, when they are at high risk for falls, they are given orders for floor mats, the nurses have access to the orders, the CNAs receive the information from their shift reports. During rounds all nursing staff should be checking the residents to make sure they have their floor mats when the residents are in bed. Review of the facility's policy and procedure titled Fall/Accident Prevention/Reduction Program Dated 04/22/23 states: Fall Prevention/Reduction Program: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Fall risk assessments are completed on admission, quarterly, annually, with significant changes, post fall and as needed. Residents with high-risk scores will have additional interventions, including but not limited to, floor mats and low beds, or other individualized devices.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48906 Based on observations, interviews and record review the facility failed to follow pharmacy procedure of less than 5% resulting in a of 6.25% medication error rate out of 31 opportunities; as evidenced by an observations of an inappropriate administration of a chewable form of aspirin, an omission of a magnesium 100 mg (milligram) capsule, and administration of insulin without providing privacy while another resident was in the room. There were 154 residents residing in the facility at the time of survey. The findings included: On 10/22/24 at 9:46 AM a medication administration observation was completed with Staff A, Registered Nurse (RN) on Medication Cart number two, in The South Wing Nursing Unit for Resident#107. Staff A, RN verified physician's orders and placed pills into one medication cup which included a chewable form of Aspirin 81 mg tablet. Staff A, RN did not place a prescribed Magnesium 100 mg capsule into medication cup and when asked the reason, Staff A, RN stated, The Magnesium 100 mg capsule was not in the medication cart and the pharmacy is aware and has not delivered it yet. It was last given yesterday. Staff A, RN then placed the cup of pills and a cup of water on top of a Styrofoam plate, knocked on Resident 107's door and asked for permission to enter. Once inside, Staff A, RN introduced self, verified resident by name and provided privacy. Staff A, RN named the medications in the cup to Resident#107, however did not state that there was a chewable form of the Aspirin nor any instruction to chew the pill separately or that the Magnesium capsule was not included. Staff A, RN attempted to administer all medications together and was stopped by surveyor before administration and asked to return to medication cart. The surveyor asked Staff A, RN if it is ok to administer the chewable form of Aspirin with the other medications without instructing the resident to chew? Staff A, RN replied, [Resident#107] usually takes all the medications together, but I can separate it. I can ask the resident if chewing or taking whole is preferred. I will get my supervisor. Staff C, RN Manager for South Wing approached the medication cart and instructed Staff A, RN that Resident#107 needs to be asked in Creole language what is the preference when taking the chewable medication and indicated that a Creole speaking staff member would assist. The surveyor asked Staff A, RN, what the facility's protocol for administering chewable medications to residents. Staff A, RN stated: I don't know the exact protocol and you can find out with the manager. I normally administer all the medications together because the resident does not like to chew the chewable Aspirin; if the resident refuses the medication I will call the physician. Staff C, RN Manager approached cart accompanied by Staff B, a Certified Nursing assistant (CNA). Staff B, CNA, (speaking Creole) asked Resident#107 if she wanted to chew the aspirin, Resident#107 agreed. Staff A, RN then administered chewable form of Aspirin to Resident #107, and Resident#107 chewed the pill. Staff A then administered the remaining medications. Staff C, RN Manager, stated When administering a chewable form of a tablet the nurse is to instruct the resident to chew before administering the medication and then it's the resident 's preference if they want to take it whole. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105252	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER Jackson Memorial Perdue Medical Center		STREET ADDRESS, CITY, STATE, ZIP CODE 19590 Old Cutler Road Cutler Bay, FL 33157	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a demographic sheet for Resident#107 revealed an admitted [DATE] with diagnosis that included: Encounter for prophylactic measures, and Nutritional deficiency. Further review of Resident#107's physician orders revealed an order dated 7/5/23 for Chewable Aspirin 81 mg tablet, chewable directions one tablet by mouth once a day for encounter for prophylactic measures and an order dated 10/11/24 for magnesium glycinate 100 mg capsule once a day at 9:00 AM for supplement. On 10/22/24 at 11:25 AM A blood glucose check and insulin administration observation was done with Staff D, RN on medication cart number one in The South wing nursing unit for Resident#135. Staff D, RN performed a blood glucose check and administered prescribed insulin for Resident #135 and did not provide privacy, there was another resident in the room at the time of the observation. The surveyor asked Staff D, RN How is privacy provided for the residents during medication administration? Staff D, RN replied, I normally close the door or pull the curtain while administering medications or testing blood glucose. I did not pull the curtain around resident or close the door because I wanted to make sure you (the surveyor) can see the procedure. Record review of a demographic sheet for Resident#135 revealed an admitted [DATE] with diagnosis that included: Type 2 diabetes mellitus without complication. On 10/24/24 at 10:15 AM, an interview was conducted with the Director of Nursing (DON). The DON stated, If a medication is ordered as chewable it should be chewed depending on resident's preference. The nurse is to instruct the resident to chew the pill before administration. The medication nurse is responsible for reordering medications when the count is low and ensuring the medication is available to be administered. Record review of Policy entitled, Nursing medication subject medication Administration and documentation revised: 4/22/24 revealed Policy: All Medications shall be ordered by an authorized provider and administered in compliance with community standard nursing policy, while accommodating residents'' preferences/requests. Procedures: F. Availability of medication: 1. Medications will be re-ordered at least five days prior to depletion of current stock.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48906 Based on observations, interviews and record review facility failed to ensure medication error rate was below 5% as evidenced by a medication error rate of 6.25% out of 31 opportunities which included an omission and an incorrect administration of a medication. There were 154 residents residing in the facility at the time of survey. The findings included: On 10/22/24 at 9:46 AM a medication administration observation was completed with Staff A, Registered Nurse (RN) on Medication Cart number two, in The South Wing Nursing Unit for Resident#107. Staff A, RN verified physicians and placed pills into one medication cup which included a chewable form of Aspirin 81 mg tablet. Staff A, RN did not place a prescribed Magnesium 100 mg(milligram) capsule into medication cup and when asked the reason, Staff A, RN stated, The Magnesium 100 mg capsule was not in the medication cart and the pharmacy is aware and has not delivered it yet. It was last given yesterday. Staff A, RN then placed the cup of pills and a cup of water on top of a Styrofoam plate, knocked on Resident 107's door and asked for permission to enter. Once inside, Staff A, RN introduced self, verified resident by name and provided privacy. Staff A, RN named the medications in the cup to Resident#107, however did not state that there was a chewable form of the Aspirin nor any instruction to chew the pill separately or that the Magnesium capsule was not included. Staff A, RN attempted to administer all medications together and was stopped by surveyor before administration and asked to return to medication cart. Staff A, RN was asked by and surveyor Is it ok to administer the chewable form of Aspirin with the other medications without instructing the resident to chew? Staff A, RN replied, Resident#107 usually takes all the medications together, but I can separate it. I can ask the resident if chewing or taking whole is preferred. I will get my supervisor. Staff C, RN Manager for South wing approached cart and instructed Staff A, RN that Resident#107 needs to be asked in the Creole language what is the preference when taking the chewable medication and indicated that a Creole speaking staff member would assist. Surveyor asked Staff A, RN What is the protocol for administering chewable medications to residents? Staff A, RN stated, I don't know the exact protocol and you can find out with the manager. I normally administer all the medications together because the resident does not like to chew the chewable Aspirin. Stated if the resident refuses the medication I will call the physician. Staff C, RN Manager approached the medication cart accompanied by Staff B, a Certified Nursing assistant (CNA). Staff B, CNA, (speaking Creole) asked Resident#107 if she wanted to chew the aspirin and Resident#107 agreed. Staff A, RN then administered the chewable Aspirin and Resident#107 chewed the pill. Staff A and RN then administered the remaining medications. Staff C, RN Manager, stated When administering a chewable form of a tablet the nurse is to instruct the resident to chew before administering the medication and then its resident preference if they want to take it whole. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a demographic sheet for Resident#107 revealed an admitted [DATE] with diagnosis that included: Encounter for prophylactic measures, and Nutritional deficiency. Record review of physician's order sheet for Resident#107 revealed an order dated 7/5/23 for Chewable Aspirin 81 mg tablet, chewable directions one tablet by mouth once a day for encounter for prophylactic measures, and an order dated 10/11/24 for magnesium glycinate 100 mg capsule once a day at 9:00 AM for supplement. On 10/24/24 at 10:15 AM An interview was conducted with Director of Nursing (DON) related to the identified concerns. The DON stated, If a medication is ordered as chewable it should be chewed depending on residents' preference. The nurse is to instruct the resident to chew the pill before administration. The medication nurse is responsible for reordering medications when the count is low and ensuring the medication is available to be administered. Record review of Policy entitled, Nursing medication subject medication Administration and documentation revised: 4/22/24 revealed Policy: All Medications shall be ordered by an authorized provider and administered in compliance with community standard nursing policy, while accommodating residents'' preferences/requests. Procedures: F. Availability of medication: 1. Medications will be re-ordered at least five days prior to depletion of current stock.

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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. 42532 Based on observations, interviews and record review, the facility failed to demonstrate effective plan of actions were implemented to correct identified quality deficiencies in the problem area related to repeated deficient practices for F656 Develop/Implement Comprehensive Care Plans related to the facility failed to implement interventions of place bilateral floor mats by the bed for Resident # 78 and Resident #151 and F689 Free of Accidents Hazards/ Supervision/Devices related to the facility failure to ensure the safety measures were implemented for Resident #78, and Resident #151. there were 154 residents residing in the facility at the time of the survey. The findings included: Record review of the facility's survey history revealed, during a recertification survey with exit dated July 13, 2023. F656 Develop/Implement Comprehensive Care Plans was cited related to failure to implement care plan interventions related to bleeding precautions for two residents (Resident # 89, and Resident # 93) and the facility failed to develop and implement a comprehensive care plan related to a nephrostomy tube for one resident (Resident # 89) F689 Free of Accidents Hazards/Supervision/Devices the facility failed to provide a safe environment related to bed side rail pads to prevent accidents for one Resident (Resident# 89). Interview with Administrator on 10/24/24 at 01:49 PM. She stated the Quality Assurance and Performance Improvement (QAPI) committee had the monthly meeting on the third Thursday each month. The committee members include Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Pharmacy Consultant, Dietary Manager, Registered Dietitian, Medical Records, MDS Coordinator, Social Services Director, Maintenance Director, Housekeeping Director, Departments Heads, one nurse and a Certified Nursing Assistant. Reviewing the last time meeting and had a quick discussion. Quality Assurance is monitoring continuously, communicate with the head of the department to always ensure tracking of the issues; always looking at new ideas to enhance and expedite the work being done. For concerns related to Develop/Implement Comprehensive Care Plans and Free of Accidents Hazards/Supervision/Devices, all staff will have in-services education conducted by the Director of Nursing/ Assistant Director of Nursing regarding care plans implemented to residents to ensure the safety of residents. A facility wide audit will be done to ensure all residents with interventions of bilateral floor mats were placed by the bed to prevent falls. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Policy and procedures revealed the facility organization has a comprehensive, date-drive Quality Assurance Performance Improvement Program that focuses on indicators of the outcomes of care and quality of life. Procedure: Program Design and Scope: The entire facility is involved in the QAPI program including all Department Heads and addresses all systems of care and management practices, including clinical care, quality of life, and resident's choices. The overall aim is to improve safety and quality of care, while emphasizing individuality in the daily life of our residents. All best practices are adopted in clinical interventions. Purpose: Our facility purpose is to improve the overall satisfaction of our Residents relating to care, services and disease management, specialized rehabilitative programs and transitions of care, discharge planning and more. We do so by involving al of our TEAM members in ensuring our success. We also strive to implement a preemptive approach to continually improving the manner in which we care for our residents, staff and visitors so we may make our visitors the best choice for providing high quality care.