

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 04/30/2026
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.			
(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	<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** F689Based on observations, record review and interviews the facility failed to provide an environment as free of accident hazards as possible for one (Resident # 45) out of two sampled residents who smoke as evidenced by observation of cigarettes and a lighter on the wheelchair in the room of Resident #45. There were 14 residents listed as smokers residing in the facility at the time of survey. The findings include: Observation on 04/27/2026 at 8:15 AM revealed Resident # 45 in bed with no apparent distress; there was a wheelchair positioned before Resident # 45's bed. Two boxes of cigarettes were on wheelchair's cushion and a lighter below the wheelchair's cushion. Record review of Resident # 45's clinical records the resident was readmitted to the facility on [DATE] with diagnosis that included but not limited to: Muscle weakness. Record review of Resident #45's Quarterly Minimum Data Set (MDS) reference dated 04/01/2026 revealed Resident # 45 had a Brief Interview for Mental Status score of 15, indicating no cognitive impairment, was independent for Activities of Daily Living and use a wheelchair and no behavior concerns since admission/entry or reentry or the prior assessment. Record review of Resident # 45's care plans revealed the resident was care planned for smoking cigarette less than hourly, deemed safe smoker if supervised by staff starting on 06/30/2025 and last reviewed/ revised on 04/05/2026 with approaches that included: Offer, educate and encourage resident to use smoking apron for safety. Record review of the facility's policy titled, Smoking, Vaping, E-Cigarettes & Contraband Revised: 01/15/2026 indicated: Purpose: To protect the health of all persons within the facility because smoking and contraband are a health risk, fire/safety hazard, and is potentially a danger to self and others. To abide by federal resident rights regulations, which allow residents of nursing homes to smoke in designated areas. This operating procedure also provides standards and guidelines for the search and removal of contraband at JHS. Policy: Smoking is prohibited anywhere on JHS property, except for designated areas in the nursing homes. It is prohibited for all employees, visitors, families, volunteers, contracted personnel, vendors or anyone who is not a resident. Smoking is prohibited in any official JHS vehicle. The possession, consumption or sale of alcohol, or contraband on JHS property is prohibited. It is the policy of JHS that items which pose a significant potential danger to residents, staff or visitors be seized secured by the appropriate department within the facility or law enforcement. A. Residents shall not keep matches nor lighters with them, nor in their rooms. Residents are assessed periodically (annually) to determine level of independence with smoking. Designated smoking areas are located on the North wing patio. Smoking patios are open between and is generally allowed between 8:00 AM - 9:00 PM daily. Smoking after 5:30 PM is highly discouraged, to promote smoking cessation and ensure safety of both residents and staff. The use of E-cigarettes are not permitted at JMPMC. On 04/27/2026 at 8:16 AM Resident # 45 stated: I smoke one cigarette a day around 5:00 PM in the north wing patio. I keep my cigarettes and lighter under the cushion of my wheelchair. I get out the bed on my own and go to smoke. During an interview on 04/27/2026 at 8:23 AM Staff H, Certified Nursing Assistant (CNA) revealed Resident # 45 is independent and goes to smoke in the north wing patio. Surveyor asked if Resident # 45 is allowed to keep smoking supplies and Staff H, CNA replied, He doesn't let you keep (continued on next page)</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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>anything for him. Interview on 04/27/2026 at 8:27 AM Staff E, Registered Nurse (RN) revealed Resident # 45 goes independently to the north wing patio to smoke and is alert and oriented. The cigarettes and lighters are stored in a safe, and residents cannot keep the lighter. On 04/27/2026 at 8:29 AM Staff C, RN, East Wing Unit Manager stated: Residents who are alert and oriented can keep cigarettes on their person but not lighter. Staff check on a daily basis to make sure there are no lighters because it is a fire hazard. During an interview on 04/27/2026 at 9:09 AM the Director of Nursing (DON) was made aware of the identified concern. The DON stated: All smoking takes place on the north wing patio. We always have someone to supervise on the patio. The person who is supervising gives aprons to those who use them, keep the lighters locked up, and keep the keys. The residents are allowed to keep cigarettes not lighters. We allow residents to keep cigarettes to maintain a level of independence. I would not want them to keep the lighters because it is a safety concern. On 04/27/2026 at 9:59 AM The Risk Manager stated, My goal is to reduce injury; only residents who are alert and oriented and who can smoke independently can keep their cigarettes. Otherwise, a staff member keeps the cigarettes and lighters. Residents should never keep their lighters on them and if the lighter is plain sight we remove it. I spoke to [Resident # 45], and he gave us the lighter.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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>Based on observations, record review and interviews, the facility failed to maintain an accurate accounting of controlled substances on one of three medication carts reviewed as evidenced by two inaccurate controlled substance records identified for the North Wing's Red Medication Cart. The facility had a total of six medication carts at the time of survey. The findings included: On 04/27/2026 at 11:00 AM, during a medication cart check and narcotic accounting review conducted with Staff F, Registered Nurse (RN) on the North Wing's Red Medication Cart the following narcotic accounting discrepancies. Review of Resident #97's narcotic accounting log for Tramadol Hydrochloride (HCL) 50 milligram (mg) tablet by mouth every 12 hours for non-acute pain documented 22 tablets remaining. However, the medication bingo card had 21 pills (photo). Review of Resident #109's narcotic accounting log for balance of 52 Oxycodone-Acetaminophen 5 per 325mg tablets via gastric tube every 12 hours for nonacute pain recorded 52. However, the medication bingo card had 51 pills (photo). On 04/27/2026 at 11:13 AM, Staff F, RN explained that the facility's policy regarding controlled medication accounting required recording the time in the computer and signing the log to indicate how many pills remained when a controlled medication was removed from the bingo card. Interview on 04/27/2026 at 11:15 AM Staff D, RN/North wing Unit Manager stated: I trained nursing staff to sign the narcotic book at the beginning of the shift and the end making sure the paper matches the bingo card. If a nurse pulls a controlled medication, they sign the book at the time the medication is pulled. On 04/27/2026 at 2:45 PM, the Director of Nursing revealed nurses must sign at the time a pill is removed to keep the reconciliation form accurate. Record review of the facility's policy and procedure titled Controlled Medications date: 11/19/2025 Policy: Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and recordkeeping in the facility, in accordance with federal and state laws and regulations. Procedures: 6. When a controlled medication is administered, the licensed nurse administering the medication immediately enters all of the following information on the accountability record: Date and time of administration. Amount administered. Signature of the nurse administering the dose, completed after the medication is actually administered.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observations, interviews and record review the facility failed to ensure kitchen staff were wearing a beard restraint. This has the potential for hair to come in contact with food. The findings included: Record review of the Personal Appearance and Conduct Restraint Policy and Procedure (reviewed 06/11/2025) documented the following: Purpose: To establish standards for nutrition services employees that promote neat appearance that will ensure efficient, safe and sanitary operations in the preparation and service of the food consumed by all residents, staff and guests in the facility; Procedure: 1) Employees working in the Nutrition Services Department wear hairnets or coverings that cover all of the hair. Second observation of the kitchen on 04/29/2026 at 10:56 AM revealed Staff A, [NAME] with a beard and not wearing a beard guard. He was taking temperatures of food items on the lunch tray line. Interview with Staff A, [NAME] on 04/29/2026 at 11:08 AM. He confirmed that he was not wearing a beard guard and he was supposed to have one on. Observation of Staff B, Food Service Worker and the Certified Dietary Manager on 04/29/2026 at 11:13 AM revealed the workers with a beard and not wearing a beard guard. Interview with Staff B, Food Service Worker on 04/29/2026 at 11:14 AM. He confirmed that he was not wearing a beard guard and he was supposed to have one on. Interview with the Certified Dietary Manager on 04/29/2026 at 11:15 AM. He confirmed that he was not wearing a beard guard and should have one on. Interview with the Director of Nutrition Services on 04/29/2026 at 11:16 AM. She stated, I guess going forward, they should be wearing a beard guard, if they have one. Review of the Food Code of the [] a federal program, the current standards of practice is that the food service staff must wear hair restraints such as a hairnet, hat, and/or beard restraint to prevent hair from contacting food.</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>Based on observations, interview and record review, the facility's Quality Assurance and Performance Improvement Activities (QAPI/QAA) failed to demonstrate an effective plan of action to correct repeated deficiencies in the problem area as evidenced by repeated deficient practices for F0689-Free of Accident and Hazards/Supervision/Devices and F0867; QAPI/QAA improvement activities. There were 147 residents residing in the facility at the time of survey. The findings included: Record review of the facility's survey history revealed the facility was cited for F689 and F867 during the recertification and Re-licensure survey with an exit date of October 24, 2024. Review of the Quality Assurance and Performance Improvement (QAPI) Committee Meeting Sign-in Sheets dated 02/17/2026, 03/17/2026 and 04/21/2026 revealed the facility had a QAA Committee meet monthly and attendees included: Administrator, Medical Director, Director of Nursing (DON), other department heads and staff members. During an interview on 04/30/26 at 2:45 PM with the Administrator stated, On 04/30/2026 at 2:26 PM The Administrator stated, The members include Medical Director, Nursing home administrator, Pharmacist, Compliance director, Infection Preventionist, and some nurses. We meet every month and as needed to identify trends, provide quality of care quality life and to improve the system we have in place. Record review of the facility's Quality Assurance Performance Improvement Plan Policy and Procedure reviewed on 02/16/2026 revealed Policy: The facility must develop, implement, and maintain a effective, comprehensive, data-driven Quality Assurance and Performance Improvement Committee, Plan and Program (QAPI) program that focuses on indicators of the outcomes of care and quality of life. This committee shall meet on a monthly basis and shall have members consisting of the facility Risk Manager, Administrator, Director of Patient Care Services, Medical Director, Pharmacy Consultant, Infection Control Preventionist, Unit Managers, Maintenance, Environmental Supervisor, Social Work, Dietary personnel, Activities Supervisor and APRN. The Administrator is responsible for the Quality Assurance Performance Improvement Committee, Plan and Program (QAPI). Purpose: To implement a preemptive approach to continually improve the manner in which we care for our residents, staff and visitors, so that we may realize our vision of providing and delivering the highest level of care and quality of life. To address all systems of care and management practices, including clinical care, quality of life, and residents' choices. To utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents in our SNF. To reflect the complexities, unique care, and services that our facility provides. To assess resident care practices; review facility quality indicators, facility incident reports, deficiencies cited by AHCA, and resident grievances; and develop plans of action to correct and respond quickly to identified quality deficiencies.</p>		