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

Printed: 07/02/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105331	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/16/2026
NAME OF PROVIDER OR SUPPLIER Aventura Rehab and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1800 N E 168th Street North Miami Beach, FL 33162	

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility did not implement a fall care plan for one (Resident #95) of five sampled residents. Resident # 95 in bed, which was positioned high, and the call light was out of reach. There were 24 residents on the facility's Fall Management Program at the time of survey. The findings included: On 04/13/2026 at 9:17 AM, Resident # 95 was observed in a bed positioned at a high level, with the call light placed out of the resident's reach. (Photo evidence) The surveyor remained with the resident.On 04/13/2026 at 9:22 AM Staff L, Certified Nursing Assistant (CNA) returned to room and was notified about the identified concern and stated, Sorry.Record review of Resident # 95's clinical records revealed the resident was admitted to the facility on [DATE] and readmitted on [DATE]. Clinical diagnoses include but are not limited to: Alzheimer's disease, and Atherosclerotic heart disease of native coronary artery without angina pectoris.Record review revealed Resident # 95 was care planned for at risk for falls related to weakness, history of fall, medication regimen initiated on: 06/07/2025 and revised on: 04/14/2026 with interventions that included: Bed in lowest position Record review of Resident #95's physician's order sheets revealed an order dated: 03/25/2026 for fall precaution every shift.Record review revealed a 5-day Minimum Data Set (MDS) reference dated 03/30/2026 indicated in the cognitive section that Resident # 95 had a Brief Interview of Mental Status score of 4 out of 15 meaning severe cognitive impairment and the functional section documented the resident was dependent on staff for toileting and hygiene.Interview on 04/13/2026 at 9:48 AM Staff L, CNA stated, I always lower the bed, but I forgot because I went to the hallway to ask for the assistance of another staff to help me transfer the resident into the chair. I know I am supposed to lower the bed before I leave the room.On 04/13/2026 at 10:39 AM the nursing supervisor Registered Nursing (RN) was interviewed about the facility's policy for fall prevention and stated, The CNA is supposed to leave the bed in the lowest position for safety.On 04/13/2026 at 12:18 PM, Staff G, RN was made aware of identified concern and revealed rounds are done to ensure safety.On 04/14/2026 at 9:24 AM The Director of Nursing (DON) stated, Some interventions to prevent falls include keep the bed in the lowest position when not in room with the resident. For those who are not able to control their bed we must ensure bed is low at all times when staff are not present because that can cause a fall with injury.Record review of the facility's policy titled, Care Plans, Comprehensive Person-Centered revised January 2026 revealed Policy StatementA 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 ImplementationThe Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident.The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.

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

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

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on observations records reviewed and interviews it was determined that the facility did not accurately complete Level I Preadmission Screening and Resident Review (PASRR) forms for one out of three sampled residents diagnosed with a Serious Mental Illness (SMI). Resident # 9's diagnosis of Anxiety was omitted on the Level I PASRR form despite being admitted to the facility with this diagnosis. There were 78 residents residing in the facility. The findings included: Resident # 9On 04/13/2026 at 9:40 AM Resident # 9 was observed in bed, no apparent distress noted.On 4/17/2026 at 11:48 AM Resident # 9 was observed in a recliner in room singing loudly and stating ownership of the facility. Record review of a demographic sheet for Resident #9 revealed an admission date of 11/08/2022 and readmission date of 03/13/2026 with diagnosis that included: Anxiety, Unspecified Mood Affective Disorder, Major Depressive disorder recurrent severe with Psychotic symptoms, and unspecified Psychosis. Record review of an Annual Minimum Data Set (MDS) reference dated 07/24/2025 revealed Resident # 9 was not considered by the state Level II Preadmission Screening and Resident Review (PASRR) process to have serious mental illness and/or intellectual disability or a related condition, had diagnosis that included: Depression and Psychotic disorder.Record review of Resident #9's care plan initiated 07/03/2025 and revised: 03/19/2026 indicated the resident is at risk for drug-related side-effects related to use of psychotropic medication for diagnosis of Depression. 03/13/2026 readmitted from hospital with diagnosis: Anxiety. Intervention included: Anti-anxiety therapy: Observe for possible side-effects: Drowsiness, lack of energy, clumsiness, slow reflexes, slurred speech, confusion and disorientation, depression, impaired thinking and judgment, Record review of a March 2026 physician's order sheet revealed Resident # 9 had orders dated 03/13/2026 for Lorazepam oral tablet 0.5 milligrams (mg) controlled drug. Give 1 tablet by mouth as needed for Anxiety one tablet twice a day as needed for Anxiety.Record review of the most recent PASRR dated 03/17/2026 completed by the Social Services Director revealed Section I: PASRR Screen Decision-Making A. MI or suspected MI (check all that apply): Depressive disorder was checked. Anxiety was not checked.On 04/15/2026 at 1:57 PM The Social Services Director stated, I completed the PASSR for [Resident # 9]. When residents are readmitted from the hospital, I review the PASRR if there were discrepancies, I would complete a new PASRR. The surveyor asked if Anxiety was to be included due to Resident #9 taking a medication for Anxiety upon admission. The Social Services Director replied, I made a mistake.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, records reviewed and interviews it was determined that the facility failed to provide care and services in accordance with professional standards for administering medications via Percutaneous Endoscopic Gastrostomy (PEG) tube for one out of two sampled residents (Resident #52) with a PEG tube. Facility staff did not check the placement of Resident #52's PEG tube before administering medications. This practice had the potential to cause severe medical complications. There were four residents with PEG tubes residing in the facility at the time of survey.The findings included: Observation on 04/13/2026 at 10:00 AM of medication administration for Resident # 52 being performed by Staff G (RN) revealed after verifying physician orders and preparing four medications in separate cups, Staff G entered the room, ensured privacy, performed hand hygiene, collected water, and donned gloves. Resident #52 was awake in bed with tube feeding off. Staff G attached a 60 ml syringe to the PEG valve, administered 30 ml of water, but did not check placement or residual. Four medications were given via PEG: 5 ml multivitamin liquid, 10 ml vitamin C (500 mg) liquid, 100 ml Levetiracetam (10 mg/ml) liquid, and crushed Metoprolol Tartrate (50 mg) mixed with 5 ml water, flushing with 30 ml of water between doses.Record review of a demographic sheet revealed Resident #52 was admitted on [DATE] with diagnosis that included: Hemiplegia and Hemiparesis following cerebral infarction affecting non-dominant side, and Encounter for attention to gastronomy. Review of a Minimum Data Set reference dated 3/22/2026 revealed Resident # 52 had a Brief Interview of Mental Status score of 7, indicating moderate cognitive impairment and had a feeding tube. On 04/13/2026 at 11:10 AM, the nursing supervisor, RN was interviewed about the facility's policy and procedure for administering medications through an enteral tube and stated, Nurses are to check for placement and residual before administering any medications via an enteral tube because it could pose an aspiration danger to the resident. The nursing supervisor RN was then notified of the identified concern.During an interview on 04/13/2026 at 11:13 AM Staff G, RN was asked about the facility's policy and procedure for checking placement and residual before administering medications through an enteral tube; Staff G, RN stated: I did not check for placement or residual for [Resident # 52] because I forgot.On 04/14/2026 at 9:41 AM the Director of Nursing was made aware of the identified concern.Record review of the facility's policy titled, Administering Medications through an Enteral Tube revised January 2026 revealed Purpose:The purpose of this procedure is to provide guidelines for the safe administration of medications through an enteral tube Steps in Procedure:6. Verify placement of feeding tube:a. If you suspect improper tube positioning, do not administer feeding or medication. Notify the Charge Nurse or Physician.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to provide an environment free of accident hazards for one (Resident # 95) out of five sampled residents on fall management program; and on the fourth floor and with the fourth-floor housekeeping cart as evidenced by; Resident # 95 was left in a high positioned bed, the call light not in reach while and no staff present. There were 24 residents on the facility's Fall Management Program at the time of survey. 2) Housekeeping cart left unattended with hazardous chemical easily accessible on the cart. There were 78 residents residing in the facility at the time of survey. The findings included: On 04/13/2026 at 9:17 AM, Resident #95 was observed in a bed positioned at a high level, with the call light placed out of the resident's reach. (Photo evidence) The surveyor remained with the resident.On 04/13/2026 at 9:22 AM Staff L, Certified Nursing Assistant (CNA) returned to room and was notified about the identified concern and stated, Sorry.Record review of Resident # 95's clinical records revealed the resident was admitted to the facility on [DATE] and readmitted on [DATE]. Clinical diagnoses include but are not limited to: Alzheimer's disease, and Atherosclerotic heart disease of native coronary artery without angina pectoris.Record review revealed Resident # 95 was care planned for at risk for falls related to weakness, history of fall, medication regimen initiated on: 06/07/2025 and revised on: 04/14/2026 with interventions that included: Bed in lowest position Record review of Resident #95's physician's order sheets revealed an order dated: 03/25/2026 for fall precaution every shift.Record review revealed a 5-day Minimum Data Set (MDS) reference dated 03/30/2026 indicated in the cognitive section that Resident # 95 had a Brief Interview of Mental Status score of 4 out of 15 meaning severe cognitive impairment and the functional section documented the resident was dependent on staff for toileting and hygiene.Interview on 04/13/2026 at 9:48 AM Staff L, CNA stated, I always lower the bed, but I forgot because I went to the hallway to ask for the assistance of another staff to help me transfer the resident into the chair. I know I am supposed to lower the bed before I leave the room.On 04/13/2026 at 10:39 AM the nursing supervisor Registered Nursing (RN) was interviewed about the facility's policy for fall prevention and stated, The CNA is supposed to leave the bed in the lowest position for safety.On 04/13/2026 at 12:18 PM, Staff G, RN was made aware of identified concern and revealed rounds are done to ensure safety.On 04/14/2026 at 9:24 AM, the Director of Nursing (DON) stated, Some interventions to prevent falls include keep the bed in the lowest position when not in room with the resident. For those who are not able to control their bed we must ensure bed is low at all times when staff are not present because that can cause a fall with injury. Observation on 04/13/2026 at 9:10 AM observation on the fourth floor revealed a housekeeping cart with a spray bottle easily accessible and unattended (photo evidence). On 04/13/2026 at 12:19 PM a follow up observation revealed the spray bottle remained easily accessible while the housekeeping cart was unattended. On 04/13/2026 at 12:21 PM Staff F, housekeeping staff was interviewed revealed chemicals are to be kept locked; the surveyor asked to view spray bottle noted marked danger (photo evidence).On 04/13/2026 at 12:31 PM, the Housekeeping Director was made aware of the identified concern and stated, Staff are to keep all chemicals locked in the housekeeping cart for the safety of residents. Record review of the facility's Policy and Procedures titled, Fall Prevention Program dated 12/2000 revised January 2026 revealed Policy:In the interest of resident's safety, it is the responsibility of ALL personnel at University Nursing & Rehab Center to participate in the fall prevention program. All falls cannot be prevented; however, prevention can minimize risk of accidents and injury.A Fall Risk Observation will be completed by the admitting licensed nurse within twenty-four (24) hours of admission and/or readmission to determine the resident's fall potential. The DON, ADON or designee shall review the fall risk assessment within forty-eight (48) hours of admission.Resident identified as high risk shall be put on Fall Prevention Program.The fall prevention (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	program will be coordinated/monitored by the ADON or Resident Assessment Coordinator (RAC) orOBJECTIVES:To ensure those residents at risk for falls is identified early and appropriates interventions are implemented in a timely manner.To minimize risk of fall-related injury.PROTOCOLS:Establish protocols for fall investigation (e.g, clinical problems, medications, unsafe environment, history of falls/syncope, adverse resident interactions).Involve Interdisciplinary Team: Administration, Nursing, Social Services, Housekeeping, Maintenance, Dietary, Activities, Rehab, Restorative, Residents and Family.Track ALL falling incidents to determine patterns and implement active preventative steps. Investigate falls that could have been prevented and counsel/in-service staff when necessary.Identify residents at high risk for falls and take appropriate steps to reduce risk of injury.

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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** Based on observations, interview and record review the facility failed to provide pharmaceutical services to ensure accurate and timely medication administration for two (Resident # 52 and Resident #73) out of five residents reviewed for medication administration observation as evidenced by:1 An omission of a supplement order for Resident # 52 for wound healing. 2. Medications administered 1.5 to 2 hours late to Resident # 46 and Resident #73. There were 78 residents residing in the facility at the time of survey. The findings included:Resident # 52 Observation on 04/13/2026 at 10:00 AM of medication administration for Resident # 52 being performed by Staff G, Registered Nurse (RN) revealed after verifying the physicians' orders and preparing four medications in separate medication cups, Staff G, RN knocked, obtained permission, verified the resident's identity, provided privacy, washed hands, and collected water. Resident #52 was awake in bed with the tube feeding off. Staff G donned gloves, used a barrier, attached a 60 mL syringe to the PEG valve, and gave 30 milliliters (ml) of water Staff G, RN did not check for placement or residual. The following medications were given via PEG with 30 ml water flushes between each: Multivitamin liquid, Vitamin C liquid, Levetiracetam liquid, and crushed Metoprolol Tartrate oral tablet mixed with 5 ml water. A Medication reconciliation revealed Resident #52 had physician orders dated 04/04/2026 for House Liquid protein one time a day for wound healing 30 milliliters (ml) in 120 ml water via PEG daily. Orders dated 01/17/2026 for Levetiracetam Oral Solution 500 milligrams per 5 milliliters (mg/5ml). Give 10 ml via G-Tube two times a day related to Unspecified Convulsions, Multiple Vitamins-Minerals one time a day for Vitamin Supplements 5 ml via PEG daily, Vitamin C 500 mg one time a day for Vitamin Supplements and an order dated 02/09/2026 for Metoprolol Tartrate Oral Tablet 50 mg; give 1 tablet by mouth two times a day for Hypertension. The ordered House Liquid protein was not administered during the medication observation. Record review of a demographic sheet revealed Resident # 52 was admitted to the facility on [DATE] with diagnosis that included: Hemiplegia and Hemiparesis following cerebral infarction affecting non-dominant side, and Encounter for attention to gastronomy. Further review of a Minimum Data Set reference dated 3/22/26 revealed Resident # 52 had a Brief Interview of Mental Status score of 7, indicating moderate cognitive impairment. Record review of a care plan initiated: 01/30/2026 and revised on: 01/30/2026 revealed Resident # 52 was care planned for risk for skin impairment related to: incontinence, risk for malnutrition/malnutrition, weakness/decreased mobility, history of resolved ulcer with interventions that included: Nutritional supplements/diet as ordered. On 04/13/2026 at 1:21 PM Staff G, RN was interviewed about the facility's policy for administration of medications and supplements stated, I administer according to the physicians order and sign after administering. The surveyor asked Staff G, RN why the Protein liquid was not administered during the observation and Staff G, RN replied: I was waiting until the feeding was off. I am going to administer now. At that time Staff G, RN and surveyor reviewed the Electronic Medication Administration Record (EMAR) and noted Staff G, RN's signature dated 4/13/2026 at 10:56 AM for protein liquid indicating (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the medication was given during the medication observation (photo). Surveyor asked Staff G, RN the facility's protocol for signing medication administration record and Staff G, RN replied, I can strike it out. I am supposed to only sign for medications and supplements given. On 04/14/2026 at 9:41 AM the Director of Nursing (DON) was interviewed about the facility's policy and procedure for administering medications and supplements. The DON stated: Nursing staff administer according to the physician's order then sign the EMAR after administration. The staff should never sign the EMAR unless they administered the medication or supplement. Resident # 46 On 04/13/26 at 10:14 AM, the surveyor observed Staff A, Registered Nurse (RN), administering medication on the first-floor south cart for Resident #46. Staff A, RN revealed that Resident #46 received medications orally in whole form. Staff A, RN performed hand hygiene, implemented required infection control precautions, verified each medication, and prepared them according to the physician's order. Staff A, RN administered the oral medications, ordered for 9:00 AM, with water: 1. Staff A, RN administered Amlodipine 10 milligrams (mg), 1 tablet, by mouth (PO); ordered to be given once daily. 2. Staff A, RN administered Doxycycline 100 mg, 1 capsule (cap), PO; ordered to be given twice daily; the 9:00 AM dose was observed. 3.Staff A, RN performed hand hygiene, applied gloves, cleaned the resident's upper left arm with an alcohol pad, and administered the Lovenox injection 40 mg/0.4 milliliter (ml), 1 syringe, at an intramuscular (IM) site. The resident displayed signs of discomfort during and after the injection. Staff A, RN removed gloves and gown, washed her hands, disposed of the syringe in the sharps' container, and signed off in the computer. A review of Resident #46's physician's orders showed that Lovenox injection 40 mg/0.4 milliliter (ml), 1 syringe, subcutaneous (sub q), was ordered to be given once daily at 9:00 AM. When the surveyor inquired about the site used for the Lovenox injection, Staff A, RN responded that she inserted the needle at a 15% angle. Record review of Resident #46's admission records revealed the resident was initially admitted to the facility on [DATE] and readmitted on 04/06/. Clinical diagnosis included but not limited to: Aftercare following joint replacement surgery, Infection and inflammatory reaction due to internal left knee prosthesis, Essential (Primary)Hypertension and Long term (Current) use of Anticoagulants. Resident #73 On 04/13/26 at 11:05 AM, medication administration was observed being carried out by Staff A, RN, on the first-floor south cart for Resident #73. Staff A, RN indicated that Resident #73 receives oral medications in whole form. Staff A, RN completed hand hygiene and verified each medication against the physician's order, then proceeded to prepare and administer the following scheduled 9:00 AM medications with water. 1. Multiple Vitamins, 1 tablet by mouth (PO), once a day scheduled to be given at 9:00 AM. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Carvedilol 25 mg tablet. 1 tablet by mouth twice a day (the ordered 9:00 AM dose observed). 3. Clopidogrel 75 mg tablet. 1 tablet by mouth once a day scheduled to be given at 9:00 AM. 4. Fluoxetine 20 mg tablet. 1 tablet by mouth once a day scheduled to be given at 9:00 AM. 5. Letrozole 2.5 mg tablet. 1 tablet by mouth, once a day scheduled to be given at 9:00 AM. Record review of Resident #73's admission records revealed the resident was admitted to the facility on [DATE] with clinical diagnosis that include but not limited to type 2 diabetes mellitus, Chronic Obstructive Pulmonary Disease, Parkinson's disease, Sepsis unspecified Urinary Tract Infection and Malignant neoplasm of unspecified site female breasts. During an interview on 04/13/2026 at 11:05 AM, Staff A, RN stated: The time frame to administer medications is within one hour before or after the scheduled time. I typically have about 17 patients, which I feel is a manageable workload to complete my tasks. In this case, the medication was given later to [Resident # 46] because he was in therapy at the scheduled time and [Resident #73] asked me to come back later to give her medication. Interview on 04/15/2025 at 03:33 PM the Director of Nursing (DON) stated Medications can be given one hour before or one hour after the scheduled time. For example, 9:00 AM medication can be given between 8:00 AM and 10:00 AM. If it is given late, the nurse must notify the doctor. Record review of the facility's policy titled, Administering Medications revised April 2019, reviewed January 2026 revealed Policy Statement: Medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation: 4. Medications are administered in accordance with prescriber orders, including any required time frame. 21.The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones.

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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. Based on observations, interviews, and record reviews facility failed to ensure the medication error rate was below 5 % as evidenced by a medication rate of 24.24 %. Observations included: Medications administered 1.5 to 2 hours late to Resident #46 and Resident #73. There were 78 residents residing in the facility at the time of survey. The findings included:Resident # 46 On 04/13/26 at 10:14 AM, the surveyor observed Staff A, Registered Nurse (RN), administering medication on the first-floor south cart for Resident #46. Staff A, RN revealed that Resident #46 received medications orally in whole form. Staff A, RN performed hand hygiene, implemented required infection control precautions, verified each medication, and prepared them according to the physician's order. Staff A, RN administered the oral medications, ordered for 9:00 AM, with water: 1. Staff A, RN administered Amlodipine 10 milligrams (mg), 1 tablet, by mouth (PO); ordered to be given once daily. 2. Staff A, RN administered Doxycycline 100 mg, 1 capsule (cap), PO; ordered to be given twice daily; the 9:00 AM dose was observed. 3.Staff A, RN performed hand hygiene, applied gloves, cleaned the resident's upper left arm with an alcohol pad, and administered the Lovenox injection 40 mg/0.4 milliliter (ml), 1 syringe, at an intramuscular (IM) site. The resident displayed signs of discomfort during and after the injection. Staff A, RN removed gloves and gown, washed her hands, disposed of the syringe in the sharps' container, and signed off in the computer. A review of Resident #46's physician's orders showed that Lovenox injection 40 mg/0.4 milliliter (ml), 1 syringe, subcutaneous (sub q), was ordered to be given once daily at 9:00 AM. When the surveyor inquired about the site used for the Lovenox injection, Staff A, RN responded that she inserted the needle at a 15% angle. Resident #73 On 04/13/26 at 11:05 AM, medication administration was observed being carried out by Staff A, RN, on the first-floor south cart for Resident #73. Staff A, RN indicated that Resident #73 receives oral medications in whole form. Staff A, RN completed hand hygiene and verified each medication against the physician's order, then proceeded to prepare and administer the following scheduled 9:00 AM medications with water. 1. Multiple Vitamins, 1 tablet by mouth (PO), once a day scheduled to be given at 9:00 AM 2. Carvedilol 25 mg tablet. 1 tablet by mouth twice a day (the ordered 9:00 AM dose observed) 3. Clopidogrel 75 mg tablet. 1 tablet by mouth once a day scheduled to be given at 9:00 AM 4. Fluoxetine 20 mg tablet. 1 tablet by mouth once a day scheduled to be given at 9:00 AM 5. Letrozole 2.5 mg tablet. 1 tablet by mouth, once a day scheduled to be given at 9:00 AM During an interview on 04/13/2026 at 11:05 AM, Staff A, RN stated: The time frame to administer (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aventura Rehab and Nursing Center	1800 N E 168th Street North Miami Beach, FL 33162

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications is within one hour before or after the scheduled time. I typically have about 17 patients, which I feel is a manageable workload to complete my tasks. In this case, the medication was given later to [Resident #46] because he was in therapy at the scheduled time and [Resident #73] asked me to come back later to give her medication. Interview on 04/15/2025 at 03:33 PM the Director of Nursing (DON) stated Medications can be given one hour before or one hour after the scheduled time. For example, 9:00 AM medication can be given between 8:00 AM and 10:00 AM. If it is given late, the nurse must notify the doctor. Record review of the facility's policy titled, Administering Medications revised April 2019, reviewed January 2026 revealed Policy Statement: Medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation: 4.Medications are administered in accordance with prescriber orders, including any required time frame. 5. Medication administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include: Enhancing optimal therapeutic effect of the medication;

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, interviews, and record reviews facility failed to properly store medications during medication administration as evidenced by: Observation of medications on top of the 4th floor medication cart, unattended. Two observations of the facility's staff leaving medications unattended during medication administration. There were 78 residents residing in the facility at the time of survey. The findings included:Resident #72 Observation on 04/15/2026 at 8:58 AM during medication administration Staff B, Registered Nurse (RN) left medication at Resident #72's bedside while performing hand hygiene. Interview on 04/15/2026 at 9:28 AM Staff B, RN stated: I am not supposed to leave the pills at the bedside while washing my hands. I should bring the medication and the bedside table with me. The reason is because the patient could grab the medication and take it unsupervised, which is unsafe. I did receive training on this, most recently two weeks ago by my supervisor. On 04/15/2025 at 03:33 PM with the Director of Nursing (DON). The DON stated: The bedside table should have been brought with the medication and kept close, even when going to the bathroom, so it remains in sight. This is important for safety. 4th Floor Medication Cart On 04/15/2026 at 10:33 AM Staff G, Registered Nurse (RN) observed standing in front of the 4th floor medication cart pouring medications. At that time a pharmacy delivery arrived, and Staff G, RN stated to surveyor, I am going to place the insulin in the fridge. Staff G, RN walked away from the 4th floor medication cart, leaving medications on top of the medication cart (photo). On 04/15/2026 at 10:35 AM the Nursing Supervisor, RN was notified about the identified concern and asked about the facility's policy for medication storage. The Nursing Supervisor, RN revealed, No medications are to be left unattended for the safety of residents. On 04/15/2026 at 10:43 AM Staff G, RN returned to the 4th floor medication cart and was interviewed about the facility's policy and procedure for medication storage and stated, I left the medications on top of the cart because I went to place the new insulin in the fridge. Resident #27 Observation on 04/15/2026 at 9:07 AM, of medication administration being completed by Staff J, RN for Resident #27. Staff J, RN checked orders, dispensed medications, entered the room, verified the resident's name, and left the medications on the side table next to Resident #27 (photo) while washing hands in the bathroom. On 04/15/2026 at approximately 9:20 AM the surveyor asked Staff J, RN about the facility's policy for medication storage during medication administration and Staff J, RN replied: I left the medications on the side table while washing my hands because I thought it was okay. It is possible another resident could take the medications and I would not know. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aventura Rehab and Nursing Center	1800 N E 168th Street North Miami Beach, FL 33162

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/15/2026 at 9:38 AM the Director of Nursing (DON) stated: Medications are stored in a locked medication cart or medication room. When administering medications, staff cannot leave medications out on top of the cart and all medications should remain in eyesight for the safety of residents. Record review of the facility's policy and procedure titled, Storage of Medications revised January 2026 revealed Policy Statement: The facility stores all drugs and biologicals in a safe, secure, and orderly manner. Policy Interpretation and Implementation: 1. Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls. 9. Unlocked medication carts are not left unattended.

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NAME OF PROVIDER OR SUPPLIER Aventura Rehab and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1800 N E 168th Street North Miami Beach, FL 33162	

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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on observations, record review and interviews, 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 F761; failed to properly store and label medications during medication administration, F689; failed to prevent accident hazards. These repeated deficient practices have the potential to affect the 78 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 F761 and F689 during the recertification and Re licensure survey with an exit date of 09/19/2024.Record review of the facility's Quality Assurance and Performance Improvement (QAPI) Plan Reviewed: 3/10/2025 revealed Policy: It is the policy of this facility to develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life.Review of the Quality Assurance and Performance Improvement (QAPI) Committee Meeting Sign-in Sheets dated 03/31/2026 revealed the facility had a QAA Committee meeting monthly and attendees included: Administrator, Medical Director, Director of Nursing (DON) and other department heads. During an interview on 04/16/2026 at 2:46 PM with the Administrator/QAA and the Director of Nursing it was revealed, The members of the QAPI team include: The Medical Doctor, Administrator, Director of Nursing, department heads, and a direct care staff member. The purpose of QAPI is to discuss continuous quality improvement and review if our Performance Improvement Plans are working by using quantitative data. Surveyor made The Administrator aware of the repeated deficiency concerns that would be cited. The Administrator stated, We will address all these concerns. The administrator was notified of the identified concerns related to repeated deficiencies.