STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105392	A. Building B. Wing	02/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jackson Memorial Long Term Care Center	2500 NW 22nd Ave Miami, FL 33142

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 - 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, records reviewed and interviews, the facility failed to provide adequate supervision to prevent falls for one resident (Resident #1) out of three sampled residents reviewed for accidents and falls during a complaint investigation survey. Resident #1 a newly admitted , vulnerable and cognitively impaired had an assigned one to one (1:1) sitter was left unsupervised exited the facility through an emergency exit door descending a flight of stairs. Staff found Resident #1 at the bottom of the stairs (8 steps total) with abrasions to the bridge of the nose, right hand, and forehead. There were 172 residents residing in the facility during the survey. The findings include:Observational tour on 02/26/2026 starting at 8:18 AM of the location of the incident involving Resident #1 revealed the resident exited the facility through the South Two Emergency Exit located approximately 30 feet from the resident's room.Record Review Resident # 1's clinical records revealed the resident was admitted to the facility on [DATE] with diagnoses including but not limited to Fracture of unspecified part of left clavicle with routine healing, Traumatic Brain Injury (TBI), Impulse Disorder, Generalized Anxiety Disorder, Unspecified, and Polyneuropathy. Review of Fall assessment dated [DATE] timestamped 4:01AM revealed a Fall Risk Assessment score of 10 which indicated the resident was at risk for fall.Review of Nursing Progress Note dated 02/06/2026 timestamped 11:43 AM indicated:Resident noted with multiple trips to bathroom with watery stools. Resident with unsteady gait, and confusion. Resident on hourly rounds. Supervisor made aware and awaiting order for 1:1 supervision. Writer and ARNP (Advanced Registered Nurse Practitioner) at nurses' station working on new orders that were received from Psychiatrist regarding resident. At about 10:30 exit door alarm started to alarm, and staff was alerted to assist with resident that exited door. Writer entered area and observed resident sitting at the bottom of the steps. As writer assisted to help resident to and standing position with another staff resident noted with bleeding from right side of forehead and bridge of nose. Resident was able to walk back upstairs with two persons assist back to room. ARNP on unit at time of incident head-to-toe assessment done. Resident with 2 abrasions to right side of forehead, 1 abrasion to bridge of nose, 1 open area to right hand palm area, 1 open area to right hand 4th digit. MD (Medical Doctor) notified and gave order to transfer resident to [local hospital emergency room] 911 called.fire rescue attendants arrived in unit. Resident left unit via stretcher. Review of Physician Orders for Resident #1 revealed an order dated 02/05/2026 for 1:1 supervision to ensure safety and support cognitive recovery, and an order dated 2/05/2026 to maintain fall precautions every shift. Order dated 02/06/2026 to transfer resident to [local hospital] emergency room status post fall with abrasion to right side of forehead, nose and right hand.Record review of a Hospital Summary dated 02/07/2026 timestamped 5:39 AM revealed Computed Axial Tomography Scan (CT) results indicated no other acute traumatic injuries noted. Record review of Fall Care Plan initiated on 02/06/2026 and revised on 02/06/2026 revealed Resident #1 had potential for falls related to use of psychotropic (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

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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 - Actual harm Residents Affected - Few	medications, unsteady gait, restlessness, anxiety, agitation, status post TBI, poor safety awareness and required supervision. Revision included: Resident was found sitting at the bottom of the step with injuries noted and new order was received to transfer resident to hospital for further evaluation. Goal was that resident will be free from injurious falls through next review date. Interventions included 1:1 as indicated and maintain fall and safety precautions at all times. Interview with Staff A, Certified Nursing Assistant (CNA) on 02/26/2026 at 3;27 PM revealed when asked about Resident #1's incident and the facility's policy on 1:1 supervision, she stated: The resident asked me for some water, went to lay down in the bed, and I covered him with a sheet. I then walked 2 doors down to another room to ask who was going to cover my break. I know the facility policy for 1:1 supervision is for the sitter to maintain at the resident's bedside at all times without exceptions. Interview with Staff A, Certified Nursing Assistant (CNA) on 02/27/2026 at 11:13 AM revealed, when asked regarding facility policy on 1:1 sitter communicating with staff about break time, Staff A stated: If the sitter needs to communicate with other staff to request a break, then it should be done using the call light always. Interview with the Senior Director of Risk Manager on 02/27/2026 at 10:19 AM revealed when asked if the setting was appropriate for Resident #1 and sitter leaving him unsupervised, she responded: I do not think the resident was a candidate for long-term care. He needed more aggressive care due to his Traumatic Brain Injury and psychiatric history. I believe, due to the resident's restlessness and impulsiveness, the incident would have occurred anywhere else. I also think the resident's sitter should not have stepped away from the bedside this is why she was held accountable. Interview on 02/27/2026 at 10:46 AM, Staff B, Registered Nurse (RN) Leader on 02/27/2026 at 10:46 AM revealed a sitter's role when assigned to a 1:1 supervision is to be within one arm length from the resident and if a bathroom break is needed, it should be communicated via the call light. Interview with the Administrator on 02/27/2026 at 12:52 PM; when asked if the incident with Resident #1 could have been avoided, he stated: I do not think this incident could have been avoided because the resident was agitated since he arrived at this facility and it could have happened anywhere else. I also do not think what the sitter did was correct; she should have never left the resident alone. Interview with the Director of Nursing on 02/27/2026 at 2:08 PM revealed when asked if the setting was appropriate for Resident #1 and the facility's policy on 1:1 supervision, she stated: The facility's policy regarding 1:1 supervision is for the sitter to remain with the assigned resident at all times. If the sitter needs a break, she needs to use the call light to communicate it; there is no reason for the sitter to leave the room. I also do not think the resident was a proper candidate to be in this facility because he was agitated and had been treated with Haldol in the previous facility. Record review of the facility's Policy titled: Resident Abuse, Neglect, Exploitation and Misappropriation of Resident Property dated 04/04/2023 and revised on 04/15/2025 indicated: Policy: [NAME] Memorial Long-Term Care shall make every effort to ensure that residents are free from abuse, neglect, exploitation, mistreatment, and misappropriation of resident property.2. Neglect is defined as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Type/Example of Neglect: b. Inadequate supervision (victim left alone caregiver present but unable to provide or not providing supervision).