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	08/14/2025

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

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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 - Some	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 observation, record review, and interview, the facility failed to provide a safe environment free of potential accidents and hazards for all residents residing in the facility by failing to implement the facility's policy related to accident and hazards for five (Resident #57,Resident #68, Resident #47, Resident #112 and Resident #150) out of 45 residents sampled in the facility; as evidence by: 1) Resident #57's side rail padding was observed on the outer side of the bed rail 2) a bladed box cutter was a observed on Resident # 68's bedside table, 3) No safety floor mat on the left side of Resident # 47's bed, 4) Resident # 112 had no safety floor mat to the right side of the bed and 5) a pack of cigarettes observed in Resident #150's pant pocket. These deficient practices increase the risk of accidents, hazards and fires that could cause serious harm, serious injuries or even fatalities. There were 169 residents residing in the facility at the time of the survey. The findings include. Resident #57 During observation on 08/11/25 at 08:27 AM both of Resident #57's side rails and side pads were in place, but the right-side rail padding was observed on the outer side of the side rail, not in the proper position (photo evidence). On 08/11/25 11:43 AM Resident #57's right side rail padding still observed on the outer side of side rail (photo evidence). Review of the medical records for Resident #57 revealed the resident was admitted to the facility on [DATE]. Clinical diagnoses included but not limited to Parkinson disease…Tracheostomy Status, Gastronomy Status, Dependence on respirator(ventilator)status. Review of Resident #57's Physician's Orders Sheet for August 2025 revealed an order dated 08/06/2025 to monitor resident for seizure activity. Special instructions: padded side rails, every shift. Record review of Resident #57 's Significant Change Minimum Data Set (MDS) dated [DATE] revealed: Section C for Cognitive Patterns documented Brief Interview for Mental Status Score is unknown. Record review of Resident #57's Care Plans revealed the Resident is at risk for injuries related to seizure disorder. Interventions include- Pad side rails. Keep bed in lowest position. Monitor resident for seizures activities and obtain new orders as needed and document accordingly. (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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 08/13/2025 at 03:13 PM the Director of Nursing (DON) stated Side rail padding is in place for a resident with a seizure diagnosis to ensure safety. Nurse managers oversee the unit, while restorative staff occasionally conduct assessments. The current side rail paddings are loose because the straps are not secured close enough to the rails, and the pads are incorrectly positioned on the outside of the railing. The team is exploring better product options. There have been no incidents where the paddings failed to protect the patient during a seizure. An order is not required for side rail padding, as its use is based on nursing judgment. Interview on 08/14/2025 at 02:43 PM with Staff K, Registered Nurse (RN) stated Yes, my patient has side rail padding. The straps should be secured properly to keep the padding in place. The purpose of the pads is to protect the patient from injury. With the padding on, three side rails should be up and one down. I make sure the padding is secure by checking that all straps are tight and correctly positioned. Record Review of the facility policy and procedure titled Bed Safety & Bedrails 07/08/2024 indicate: f. Siderails may be padded for safety and/or appropriate diagnosis e.g. seizure. Resident #68 Observation on 08/11/2025 at 10:51 AM, in Resident #68’s room revealed the resident was not in the room. A box cutter with the blade inside was observed on the Resident’s bedside table. (Photo Evidence) On 08/11/2025 at 10:53 AM, the Charge Nurse was notified and stated: Oh wow, I can't believe he has that. He has been told many times that he is not supposed to have those types of items with him, but he does not listen. The Charge Nurse then removed the box cutter Record Review of Resident #68’s demographic face sheet revealed the resident was admitted on [DATE] with diagnosis that included, but not limited to Quadriplegia, C5-C7 incomplete. Record Review of Quarterly Minimum Data Set (MDS) reference dated 07/03/25 revealed Resident #68 is cognitively intact and has impairment to both sides of upper/lower extremities and used a wheelchair. Record Review of a Care Plan with start date 10/15/2024, last revised on 08/11/2025 revealed Resident #68 had episodes of anger, inappropriate/behavioral symptoms, and becomes angry or upset with staff when providing care. Resident #68 also keeps items such as scissors and cutter inside his room for his personal use. Goal: Resident #68's episode of anger/refusal of care/treatment will decrease through next review date and possible consequences/outcomes of non-compliance. Approach: Educate Resident #68 on safety concerns on facility policies. Interview on 08/12/2025 at 12:46 PM, Resident #68 was asked about the box cutter found in room; Resident # 68 stated: I know I am not supposed to have a box cutter or any type of sharp objects in my room, but I use it to cut my plants in the patio. I bought the box cutter about a month ago when I was out on day pass and I've been using it ever since. Last time I used it was four days ago in the patio, and no one said anything to me, I guess no one saw me. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 08/12/2025 at 01:06 PM, Staff A, Registered Nurse (RN) was asked about the box cutter found on Resident #68's bedside table; Staff A, RN stated: Residents are not allowed to keep any items that may cause harm to them or others, like ropes or knives. I always make rounds in the morning and during shift (every 3-4 hrs.), but I did not see the box cutter in [Resident #68's] room”. Staff A, RN also revealed she does not check Resident #68 when he returns from being out on day pass; she is only supposed to check his skin. Interview on 08/12/2025 at 01:19 PM, Staff B, Certified Nursing Assistant (CNA) stated: The policy in this facility is that residents cannot have lighters, knives or anything else that can be harmful to them. When I perform any care, or make rounds int he morning, I check their beds and bedside table for any harmful items. Staff B, CNA also reported she was not assigned to Resident #68 on the day the box cutter was found in his room. Interview on 08/12/2025 01:29 PM, Staff C, Charge Nurse stated: The protocol for hazardous items is monitoring and checking residents' rooms for dangerous items that would cause harm to them or others. I know you found the box cutter in [Resident #68's] room yesterday but there was nothing on his bedside table when we made rounds that morning. When residents return from day pass, staff always checks their belongings, skin, and pockets. Interview on 08/13/2025 at 03:02 PM, the Director of Nursing (DON) stated: Some items that residents are not allowed to have are guns and knives. We ensure residents are not keeping these items by monitoring all residents daily. Also, when residents go out to the patio, there is always a staff member there to monitor them. If residents go out on pass, the nursing staff checks them and perform a head-to-to-toe assessment upon return. In regard to [Resident #68], we did not know he had a box cutter. Interview on 08/13/2025 at 03:30 PM, when asked about Resident #68's care plan, Staff E, MDS Coordinator stated: [Resident #68's] care plan was last updated on 08/11/2025. We updated it because staff had found a box cutter in his room and was educated (along with staff) in order to be in compliance with the facility's protocols. Record Review of the facility policy and procedure titled Safety/Risk Reduction dated 04/15/25 indicated the following: It is the policy of the facility to provide a safe environment to all residents. A multi-disciplinary team approach accomplishes this goal through systems that identify opportunities to improve and/or represent a risk thus ascertaining that there are systems in place to promote a safe living and working environment. No weapons are allowed on the premises including but not limited to firearms, and hunting knives, etc. Procedure: A. Every identifiable opportunity to enhance and provide a safe and healthy environment will be addressed through the following mechanisms: 2. Monitoring Programs include: Ransom safety checks including room searches, G. All newly admitted resident's belongings are inventoried upon admission and items identified as weapons will be confiscated. A Weapon is defined as any instrument or device designed or used for inflicting bodily harm or physical damage to self or others. Some examples include but not limited to knives, (pocketknives, Swiss army knives), firearms, clubs, brass knuckles, etc. Items will be confiscated and returned to resident at the time of discharge. Resident #47 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/11/25 at 12:35 PM Resident #47 was in bed eating lunch independently. One safety floor mat was observed on resident’s left side and none on the right side (Photo evidence) and no staff was present with the resident. On 8/11/25 at 12:50 PM, the assigned nurse Staff I, Registered Nurse (RN) was notified about the identified concern and stated, When we feed residents we remove one floor mat. The surveyor notified Staff I, Registered Nurse that Resident #47 was observed eating independently and Staff I, RN replied, “I don’t know why the floor mat was not present. On 8/11/25 at 12:50 PM Staff D, Certified Nurse Assistant, was also notified about the identified concern and stated, I removed one floor mat to set [Resident #47] up for lunch. I was called away from another staff member to help and didn’t replace the floor mat. Record review of a demographic sheet revealed Resident #47 was initially admitted on [DATE] and readmitted on [DATE] with diagnosis that included: Muscle wasting and atrophy. Record review of an Annual Minimum data set referenced dated 6/2/25 revealed Resident #47 is moderately impaired cognitively and was dependent on Chair/bed-to-chair transfer. Record review of a Fall Evaluation completed on 7/15/25 revealed Resident#47 was at risk for falls. Record review of a Progress note dated 8/3/25 revealed Resident #47 was found lying on floor. Record review of a physician’s order sheet revealed an order dated 8/4/25 directions bilateral floor mattress three times a day each shift. Record review of a Care Plan started on 6/10/25, last reviewed/revised on 8/4/25 revealed Resident #47 was at risk for falls related to: muscle weakness, impaired balance, assistance with transfer and on 08/03/05 Resident #47 observed on floor, no injuries observed and approaches that included: bilateral floor mats as indicated. Record review of a Progress note dated 8/3/25 revealed Resident#47 was found lying on floor. On 8/13/25 at 3:06 PM, the Director of Nursing revealed: The floor mats should be in place when residents are in bed unattended. There is no situation where the floor mats should not be in place while the resident is in bed unattended. Resident #112 On 8/11/25 at 12:51PM Resident #112 was observed in bed. There was one floor mat on the resident's left side (Photo evidence) and no staff present with resident. On 8/11/25 at 12:52 PM the assigned nurse Staff I, RN stated, The Certified Nurse Assistant who assisted [Resident #112] to eat removed the floor mat to assist with lunch and forgot to replace it. I do frequent rounds to monitor. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/11/25 at 12:53 PM Staff D, Certified Nurse Assistant was notified about the identified concern and stated, I am assigned to [Resident#112] today. I did not remove the floor mat, and I did not assist the resident for lunch. Staff D then walked away. The Surveyor stayed with Resident #112. Staff I, Registered Nurse approached surveyor and stated, “The Hospice nurse left floor mat after assisting [Resident#112] with lunch and the hospice nurse left the facility.” Record review of Resident #112’s demographic sheet revealed the resident was admitted on [DATE] with diagnosis that included Huntington's disease. Record review of a physician’s order sheet revealed an order dated 2/23/25 directions bilateral floor mattress three times a day. Record review of a Quarterly Minimum data set referenced dated 6/1/25 revealed a Brief Interview for Mental Status score was undetermined and was dependent on Activities of daily living and transfers. Record review of a Fall Evaluation completed on 6/6/25 revealed Resident#112 was at risk for falls. Record review of a Care Plan started on 3/10/25, last reviewed/revised on 7/30/25 indicated Resident #112 had the potential for falls related to: Resident has poor safety awareness, impaired cognition, impaired balance requiring total assistance for transfers and involuntary movements and approaches that included: Bilateral floor mats. Resident #150 On 8/11/25 at 1:20 PM Resident #150 was observed leaving the room with a pack of cigarettes in pants (photogenic evidence). The surveyor interviewed Resident #150 about facility policy for smoking; Resident # 150 stated, I am going to smoke on the patio. I get my cigarettes from the nurse and keep my cigarettes on me for the day and return them at the end of the day. At that time Staff I, RN was notified about the identified concern and stated, [Resident#150] gets cigarettes from staff in the morning and keeps it until the end of the day and return any leftover cigarettes. On 8/11/25 at 1:26 PM Resident #150 was observed on patio smoking. On 8/12/25 at 10:03 AM Resident#150 was taken to the East 2, nursing station by the Administrator, two packs of cigarettes were retrieved from the 7:00 AM to 3:00 PM shift Charge Nurse who took the cigarettes from a locked drawer behind the nursing station. At that time, the East 2’s 7:00 AM to 3:00 PM shift Charge Nurse was interviewed about the facility's smoking protocol and stated, The cigarettes are kept under lock and key. Only a nurse has a key… [Resident#150] returns left over cigarettes at the end of the day. On 8/12/25 at 10:14 AM Resident #150 was escorted back to unit. No cigarettes were returned at that time. Record review of a demographic sheet revealed Resident #150 was admitted on [DATE] with diagnosis that included: Nicotine dependence. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a Quarterly Minimum data set referenced dated 6/19/2025 revealed a Brief Interview for Mental Status score of 2, out of 15 which indicates severe cognitive impairment. Record review of a Care Plan started on 9/30/24, reviewed/revised on 6/23/25 revealed Resident #150 smokes whenever on patio, refuses to wear a smoke protective gown at times and is at risk for self-burn and had approaches that included: Staff will pass out cigarette to resident as needed, staff to closely supervise/assist resident during smoking time, clothing to be checked for holes and changed if any. Record review of a Smoking Assessment completed on 7/8/25 revealed Resident #150 had a Minimal Problem of inappropriately providing smoking materials to others and was determined to be a safe smoker supervisor only. On 8/13/25 at 2:15 PM, the Administrator was notified about the identified concern and stated, The cigarettes should be accounted for, and we should be following our smoking policy. Resident is non complaint.” On 8/13/25 at 2:52 PM, the Risk Manager stated, “I complete investigations and audits. The residents are expected to turn in the cigarettes each time they come upstairs. Even though our policy states all cigarettes should be returned to the unit for [Resident #150] it is not a hazard for him to keep cigarettes in the room because this resident is alert and did not have a lighter.” The Surveyor asked how staff knew no lighter was in the room. No response. Record review of a Policy titled, “Smoking, Vaping, E-Cigarettes &Contraband Revised on 2/1/24 revealed II. 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 and secured by the appropriate department within the facility or law enforcement. SMOKING POLICY: A. Residents shall not keep cigarettes, e-cigarettes, matches nor lighters with them, nor in their rooms.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to properly position an indwelling urinary tubing to facilitate the flow of urine for one (Resident #46) out of one sampled resident with an indwelling urinary catheter, as evidenced by Resident #46's indwelling catheter tubing was positioned above bladder and kinked. This deficient practice prevented the free flowing of urine that would be accumulated in the bladder causing discomfort and increasing the risk for catheter-associated urinary tract infections and other serious medical issues. There were four residents with indwelling urinary catheters residing in the facility at the time of this survey.The findings include.During an observation on 8/11/25 at 1:01 PM, Resident #46 was standing in his room, a tubing was observed protruding from the top of the Resident's shorts and into a drainage bag that was anchored on the walker (photo evidence). Resident #46 revealed he had an indwelling urinary catheter and complained of blood in the urine. Upon further observation the tubing was kinked, and urine did not appear to be flowing freely. On 8/11/25 at 1:05 PM, Staff J, Licensed Practical Nurse (LPN) was notified of the identified concern. Staff J, LPN completed hand hygiene, put on required Personal Protective Equipment (PPE) and readjusted the tubing so it would no longer be kinked.Interview on 8/11/25 at 1:15 PM, Staff J, LPN stated, [Resident #46] has an indwelling urinary catheter that I flush with water daily. I have not flushed it today. This morning the catheter was not kinking because the resident was wearing a gown. I readjusted the tubing, and I educated the resident.Record review of a demographic sheet revealed Resident #46 was initially admitted on [DATE] and readmitted on [DATE] with diagnosis that included: Benign Prostatic Hyperplasia (BPH) with lower urinary tract symptoms note: BPH with Obstructive Uropathy and Urinary Tract Infection.Record review of a Significant Change in Status Minimum Data Set (MDS) referenced dated 7/30/25 revealed Resident 46 had no cognitive impairment and required supervision or touching assistance for toileting hygiene and an indwelling catheter.Record review of a Care Plan started on 8/4/25, last reviewed/revised on 8/11/25 revealed Resident #46 requires an indwelling urinary catheter related Benign Prostatic Hyperplasia with Obstructive Uropathy, noted unclamping catheter leg holder and touching his Indwelling catheter at times with approaches that included: resident to not play/touch his Indwelling catheter to avoid dislodgement and/or infection. Reeducate resident not to touch indwelling catheter and to keep it below the level of bladder (resident noted to place catheter above the level).Record review of a July 2025 physician's order sheet revealed [indwelling urinary catheter] care as needed, normal saline flush 30 ml (milliliters) every shift.Interview on 8/13/25 at 3:06 PM, the Director of Nursing revealed for a resident with an indwelling urinary catheter, the best method for positioning is to secure the tubing to the thigh and the bag should be positioned downward because back flow can cause an infection. The Surveyor asked the Director of Nursing (DON) if there was any policy pertaining to the proper positioning of an indwelling urinary catheter and the DON stated: No.On 8/14/25at 2:13 PM, the Registered Nurse, Infection Preventionist revealed ways to prevent Urinary Tract infections in residents with indwelling urinary catheters include positioning the catheter tubing below the level of the bladder.Record review of a policy titled, Urinary Catheter Care dated 6/26/15 revealed POLICY: Catheter care is done by the nurse or nursing assistant routinely twice daily on all residents/patients with indwelling catheters.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to implement infection control measures for three (Residents #57, Resident #98 and Resident #106) out of twenty-one sampled vulnerable Residents, as evidenced by Residents #57 and Resident #98 catheter dignity bags touching the floor; and improper hand hygiene during Resident #106's tracheostomy care. These deficient practices increase the risk for life-threatening infections. The findings included: On 08/12/2025 at 2:02 PM Resident #57's urinary catheter drainage bag was observed in a dignity bag on the floor (photo evidence). Resident #57 Review of the medical records for Resident #57 revealed the resident was admitted to the facility on [DATE]. Clinical diagnoses included but not limited to urinary tract infection (UTI). Review of the Physician's Orders Sheet for 06/03/2025 revealed that Resident #57 may use external catheter diagnosis (dx) sacral wound. Record review of Resident #57 's Significant Change Minimum Data Set (MDS) dated [DATE] revealed: Section C for Cognitive Patterns documented Brief Interview for Mental Status Score is unknown. Section GG for Functional Abilities documented the resident has impairment to both sides of the upper and lower extremities. Section H for Bladder and Bowel documented Resident #57 bowel was always incontinent. Section I for Active Diagnosis included: Candidiasis, unspecified, Cerebral infarction due to thrombosis of right posterior cerebral artery, Persistent vegetative state, Tracheostomy status, Gastrostomy status, Dependence on respirator [ventilator] status, Urinary Tract Infection (UTI), Pain, unspecified. Record review of Resident #57's Care Plans revealed Resident #57 requires an external catheter and incontinent of bowel related to Multiple wounds. At risk for skin breakdown related to incontinence and UTI. Interventions include - Observe for signs of skin breakdown/irritation and/or decreased blood circulation to penis. Provide care after each incontinent episode, apply skin barrier protector, maintain privacy. Check skin during care, notify provider if any impairment noted. Position bag below level of bladder. Use a catheter strap to reduce pulling. Resident #98 On 08/11/25 at 09:57 AM, Resident #98 urinary catheter drainage bag was observed in a dignity bag on the floor (photo evidence). Review of the medical records for Resident #98 revealed the resident was admitted to the facility on [DATE]. Clinical diagnoses included but not limited to: Traumatic subdural hemorrhage with loss of consciousness of unspecified duration, subsequent encounter. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Physician's Orders Sheet on 07/21/2025 revealed that Resident #98 had an order for External catheter care every shift, diagnosis (Dx): sacral wound. Record review of Resident #98's MDS dated [DATE] revealed: Section for Cognitive Patterns documented the BIMS Score was unknown. Section for Functional Abilities documented the resident is dependent on toileting, showering, upper and lower body dressing and bowel was always incontinent. Section for Active Diagnosis included: Traumatic subdural hemorrhage with loss of consciousness of unspecified duration, subsequent encounter, Encounter for attention to gastrostomy, Dependence on respirator [ventilator] status, encounter for attention to tracheostomy. Record review of Resident #98's Care Plans revealed Resident #98 is incontinent of bowel and bladder, however, requires an external catheter related to Multiple pressure injuries. At risk for skin breakdown r/t to incontinence and at risk for UTI. Interventions include- Provide total assistance for catheter care. Provide care after each incontinent episode, apply skin barrier protector, maintain privacy. -Check skin during care and notify provider if any impairment noted. Position bag below level of bladder. Use a catheter strap to reduce pulling. Interview on 08/13/2025 at 03:13 PM, the Director of Nursing (DON) revealed the urinary catheter should be secured to the thigh. The tubing should be draining down to prevent backflow. the catheter bag should be hanging off the side of the bed in dignity. the catheter or dignity bag should not touch the floor. if the catheter or dignity bag touch the floor the staff should change it. to prevent this from happening at any other time the staff should make sure it is properly anchored. Interview on 08/14/2025 at 02:45 PM with Staff K, Registered Nurse (RN) stated I have been an RN at this facility for three years. When the patient is lying in bed, the [] catheter should be secured to the inside of the thigh and never touch the floor. It should always be placed in a dignity bag, and neither the catheter nor the bag should ever touch the floor. If it does, I fix it immediately, because urine can flow backward and cause infection. Review of the facility’s policy and procedures tilted Infection Prevention and Control Program 02/06/2025 indicate: the purpose - Develops and implements an ongoing infection prevention and control program (IPCP), to prevent, recognize, and control the onset and spread of infection. Establish facility-wide systems for the prevention, identification, investigation, and control of infections of residents, staff and visitors. Develop and implement written policies and procedures for infection control. Ensure staff handle, store, process and transport all linen and laundry in accordance with national standards. Resident #106 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a Tracheostomy Care observation on 08/11/25 at 09:07 AM for Resident #106, Registered Nurse (Staff F) gathered the supplies, entered Resident # 106's room, identified the resident, performed hand hygiene, donned non-sterile gloves, introduced herself, and informed resident of procedure. Staff F revealed Resident # 106 was receiving oxygen (O2) at 10 liters per minute (lpm). Staff F set up sterile area with tracheostomy supplies, removed non-sterile gloves and donned sterile gloves, suctioned resident with new suction tubing, removed trach gauze, cleaned trach stoma with normal saline, peroxide, and sterile gauze, removed soiled inner cannula, discarded it into a red biohazard bag and inserted a new one, Staff F then removed soiled trach collar and discarded it in red biohazard bag, placed a new trach collar on resident, re-connected oxygen tubing , removed gloves and donned new gloves, discarded all other soiled supplies inside red biohazard bag, removed gloves and gown, exited room, discarded red biohazard bag inside red bin in the soiled utility room, washed hands, and documented care on resident's chart. Review of Resident #106's demographic sheet revealed the resident was admitted on [DATE] with diagnoses that included but not limited to Encounter for Attention to Tracheostomy, Chronic Respiratory Failure, Unspecified whether with hypoxia or hypercapnia, and Chronic Obstructive Pulmonary Disease (COPD). Record Review of Physician's Order Sheet for March 2023 revealed Resident #106 had orders that included but were not limited to: Trach care twice daily and as needed. Record Review of a Quarterly Minimum Data Set (MDS) dated [DATE] Section for Cognitive Patterns revealed a Brief Interview of Mental Status (BIMS) summary score was 0 out of 15 which indicated severe cognitive impairment. The section for Functional Abilities revealed the resident was dependent on Activities of Daily Living (ADLs). The section for Special Treatments revealed the resident was receiving oxygen therapy, tracheostomy care and suctioning, and has received respiratory therapy for 7 days for at least 15 minutes in the last 7 days. Record Review of a care plan dated 03/13/2025, revised 06/12/2025 revealed Resident #106 required oxygen therapy related to Tracheostomy dependent, Chronic respiratory failure, Hypoxia, COPD. Goals: Resident will be monitored for signs of hypoxia. Interventions included but not limited to: Administer oxygen as ordered, HOB (Head of Bed) elevated position for optimal breathing, and monitor/document respiratory status every shift. Interview 08/11/2025 at 09:23 AM, Staff F, Registered Nurse (RN) revealed: To prevent infection while performing trach care, it is important to wash your hands before and after the procedure. Every time you remove your gloves you must wash your hands and then apply new gloves. I did not wash my hands after I removed the gloves because I did not touch any surface after removing the gloves. The infection control protocol while performing trach care is to wash hands before and after care. Interview on 0811/2025 at 10:03 AM, Staff G, Charge Nurse was asked about hand hygiene practices; Staff G , Charge Nurse stated: You need to wash your hands before care, whenever you change gloves, and after completion of care. After you remove soiled gloves, you have to wash your hands regardless of whether you touched any surface or anything else. Interview on 08/13/2025 at 03:18 PM the Director of Nursing (DON) stated: Nurses should be washing hands before and after a procedure. They are required to wash their hands after removing gloves and before donning new gloves, there are no exceptions. (continued on next page)

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	08/14/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/14/2025 at 02:37 PM Infection Preventionist Nurse Manager stated: My number one education is always hand washing. When performing trach care, you make sure you wear your gown and gloves. Anytime you remove anything that is dirty, you need to remove your gloves and wash hands before putting on new gloves. Record Review of the facility Infection Control policy titled Hand Hygiene, dated 02/24/2024, revised 08/12/2025 indicates the following: To ensure that JMLTC has a comprehensive Hand Hygiene policy and that all providers, staff employees, contractors, volunteers, students, patients, and visitors are aware of and knowledgeable about the principles of hand hygiene. Procedure: 5 Moments of Hand Hygiene: Before patient contact Before clean/aseptic procedures After body fluid exposure/risk After touching a patient After touching patient surroundings Glove Usage: a. Gloves use does not replace the need for hand hygiene. Hand hygiene must be performed prior to donning gloves and after glove removal. b. Perform hand hygiene (and glove change) when moving from contaminated body site to a cleaner body site.