STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105449	A. Building B. Wing	06/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Miami Shores Nursing and Rehab Center	9380 NW 7th Avenue Miami, FL 33150

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 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, the facility failed to properly store controlled substances on three out of four sampled medication carts as evidenced by unreconciled medication monitoring/control record sheets. The facility had four medication carts. The findings included: On 6/24/2025 at 1:32 PM a medication administration observation was completed with Staff A, Registered Nurse (RN) on the west wing medication cart #1; Staff A, RN verified the physician's order, removed the controlled substance from a bingo card placed it in a medication cup; after administering the controlled substance, Staff A, RN returned to the medication cart and signed in the medication monitoring/ control record sheet to indicate the controlled substance was given. Interview on 6/24/2025 at 1:37 PM, the surveyor asked Staff A, RN about the protocol for documenting removal of a controlled substance. Staff A, RN replied, I sign the narcotic log after the resident takes the medication because if the resident refuses, I can't sign that I have given it. The surveyor asked Staff A, RN, to explain the purpose of the narcotic log and what is indicated when a substance is given or removed from bingo card and if the log needs to be accurate at all times. Staff A, RN revealed, the narcotic log indicates the substance was removed and yes the narcotic log need to be accurate at all times. On 6/24/2025 at 1:51 PM a medication storage check was completed with Staff B, Licensed Practical Nurse (LPN) on the east medication cart #1. At that time the controlled substance log was observed signed and dated with no time. Upon further review, the electronic administration record (EMAR) was observed unsigned for the controlled substance. (photo evidence) Interview on 6/24/2025 at 1:55 PM, Staff B, Licensed Practical Nurse (LPN) revealed the protocol for signing the narcotic log, Staff B, LPN stated: I administered the medication at 1:19 PM and forgot to sign. I am supposed to sign at the time I remove the medication from the bingo card. On 6/24/2025 at 1:58 PM, a medication storage check was completed on the east side medication cart #2 with Staff C, LPN, the Medication Monitoring / Control Record was observed signed, no date written, time written but the EMAR was observed signed at 8:40 AM. At 2:00 PM a second Medication Monitoring / Control Record was observed signed, no date written, no time written, amount written, amount written, amount written, amount correct, and the EMAR was signed for that medication at 9:40 AM. (photo evidence) (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/24/2025 at 2:01 PM, during the continued medication storage check with Staff C, LPN a Bingo card of controlled substances was observed with a broken seal and tape reinforcing it. (photo evidence) Interview on 6/24/2025 at 2:01 PM, Staff C, LPN revealed: I didn't have my pen so I couldn't sign the sheet. Sometimes when the pharmacy sends the medication and the bingo card needs to be reinforced so the pill doesn't fall out. Someone placed a tape to help. The correct procedure is to call the pharmacy to resend the medication. On 6/24/2025 at 3:30 PM, the Director of Nursing stated: Nurses are to verify the physicians' order, verify in the narcotic book, pop out the narcotic, sign his or her name with time date amount at the time it is taken out of the bingo card. The narcotic should always be reconciled and signed out. If there is any tear or abnormality in the bingo card it should be sent back to pharmacy. Record review of a Policy titled 4.0 Schedule II Controlled Substance Medication (undated) revealed POLICY: This policy is to ensure adherence to state and federal laws relating to the dispensing of Schedule II controlled substance medications. In a non-emergency situation, Schedule II controlled medications will NOT be dispensed without a written. or electronic prescription. In an emergency and when allowed by federal and state regulations and in compliance with the required documented follow-up procedure, Specialty RX, Inc. pharmacies WILL dispense Schedule II controlled medications upon an oral authorization but to a 72-hour supply. To dispense Schedule III-V controlled medications, an oral, written, or electronic prescription is required. A pharmacist may not dispense more than a 30-day supply of a controlled substance listed in Schedule III upon an oral prescription issued in this state. H. Dispensing of Controlled Dangerous Substance 5. When a CDS medication is administered, in addition to following proper procedure for the charting of medications, the nurse must document on the declining inventory sheet the date of administration, the quantity administered, the amount of medication remaining and his/her initials

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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 Assessment and Assurance (QAA)/QAPI) committee failed at demonstrating an effective plan of action to correct identified quality deficiency in problem areas as evidence by repeated deficient practice for F 880-Infection Prevention and Control and F 761- Label/Store Drugs and Biologicals. There were 91 residents residing in the facility at the time of the survey. The findings included: Record review of the facility's survey history revealed, during a recertification conducted on March 23, 2025 through March 26, 2025, F880- Infection Prevention & Control was cited due to the facility's failure to implement infection control procedures related to trash and food observations on the floor inside The Resident's pantry room on the East side nursing station, indwelling catheter tube touching floor, staff not wearing proper personal protective equipment (PPE) and improper hand hygiene during wound care. F761-Label/Store Drugs and Biologicals was cited related to an unattended unlocked medication cart on the west side nursing station and medication and glucometer and lancets left at a resident's bedside. Review of the facility's policy and procedure titled Quality Assurance & Performance Improvement (QAPI) Plan QAPI Goals/Purpose Statement - Our purpose is to provide excellent quality resident/patient care and services. Quality is defined as meeting or exceeding the needs, expectations and requirements of the patients cost-effectively while maintaining good resident/patient outcomes and perceptions of patient care. Our nursing home has a Performance Improvement Program which systematically monitors, analyzes and improves its performance to improve resident/patient outcomes. It recognizes that the value in healthcare is the appropriate balance between good measures, excellent care and services and cost. Scope - Our center's full range of services included in our QAPI program are post-acute care and long-term care. The QAPI committee will consist of representation from Minimum Data Set (MDS), nursing, social services, dietary, housekeeping & laundry, maintenance, medical records, activities and Risk Management/Staff education. Therapy, music therapy, human resources, resource development, business office and therapy departments will be asked for input or sit on a performance improvement project sub- committee as requested. Interview on 06/24/2025 at 3:20 PM the Administrator revealed, the QAPI (Quality Assurance and Performance Improvement) team consists of the Director of Nursing (DON), department heads, the administrator, wound care nurse, dietary staff, and the medical director. Meetings are held monthly, with the next meeting scheduled for this Thursday. The purpose of the QAPI meetings is to review quality assurance initiatives and performance improvement efforts, particularly focusing on previous citations and audit outcomes. The team evaluates post-survey findings and identifies deficiencies. Supervisors create audit forms to help track and monitor compliance. Current areas of focus include addressing previous deficiencies, improving infection control practices, ensuring privacy, preventing unattended medications, and enhancing documentation practices.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 interviews, the facility failed to meet infection control standards of practice for Resident #5 during hygiene care. This is evidenced by Staff A not performing hand hygiene, changing gloves or changing washcloths during hygiene care for Resident #5. There were 91 residents residing at the facility at the time of the survey. The findings included: On 06/24/25 at 01:13 PM, Staff A was observed not performing hand hygiene prior to the procedure. Upon the surveyor's entry into the room, the Certified Nursing Assistant (CNA) was already wearing a gown, mask, and gloves. The resident is on enhanced barrier precautions and has a Percutaneous Endoscopic Gastrostomy (PEG) tube; the PEG tube machine was noted to be turned off. The CNA removed the resident's soiled clothing, leaving the resident uncovered while filling the basin with water. Soap was added directly to the water. The CNA did not remove gloves or perform hand hygiene at any point during the procedure. The resident's face was washed using soapy water, and the same washcloth was used to cleanse the remainder of the body. After drying the resident, the CNA turned her to wash and dry her back, then applied a clean brief and gown. Following the procedure, the CNA emptied the basin, removed the gown, gloves, and mask, and discarded them in the trash. Review of the medical records for Resident #5 revealed the resident was admitted to the facility on [DATE]. Clinical diagnoses included but not limited to: Dysphagia, unspecified. Review of the Physician's Orders Sheet on 04/04/2024 revealed that Resident #5 had an order for Enhanced Barrier Precautions for peg tube use, every shift. Record review of Resident #5's Minimum Data Set (MDS) dated [DATE] revealed: Section C for Cognitive Patterns documented a Brief Interview for Mental Status (BIMS) Score of 00, on a 0-15 scale indicating the resident is cognitively impaired. Section GG for Functional Abilities documented the resident is dependent on eating, toileting, showering, sit to lying, upper and lower body dressing. Section K for Nutrition documented no or unknown loss or gain of 5% or more in the last month or loss or gain of 10% or more in the last 6 months. Record review of Resident #5's Care Plans revealed the resident requires enhanced barrier precaution related to tube feeding. Interventions include- Educate resident, responsible party or caregivers regarding enhanced barrier precaution. Follow infection control guidelines as indicated. Maintain enhanced barrier precaution as indicated during dressing, bathing/showering, transferring. providing hygiene, changing linens, changing briefs or assisting with toileting, device care or IV access line care, urinary catheter care, feeding tube care, tracheostomy/ventilator care, ostomy care, or during wound care. Record review of Resident #5's Care Plans revealed the resident has an activities of daily living (ADL) self-care performance deficit related to (r/t) diagnosis (Dx) diabetes mellitus (DM) , osteoarthritis, hyperlipidemia, dementia and gastroesophageal reflux disease (GERD). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interventions include - Apply left hand roll when out of bed for support and comfort. Apply Wedge Foam Cushion to high back WC, for positioning and comfort as tolerated. Enhanced Barrier Precautions for peg tube use. Interview on 06/24/25 at 03:30 PM with Director of Nursing (DON) stated Enhanced Barrier Precautions apply to residents with certain medical conditions, including those with PEG tubes, foley catheters, dialysis access, wounds, or surgical sites with staples. These residents require a physician's order for enhanced precautions, which must be acknowledged and signed off on every shift. Clear signage is posted outside the resident's room to guide staff on when and how to properly don and doff personal protective equipment (PPE). Non-compliance with these protocols has led to employee terminations in the past, reflecting the facility's commitment to strict adherence. Education on enhanced barrier precautions is provided weekly by the staff educator, with additional one-on-one training conducted as needed during real-time observations. During bed baths, gloves should be changed after cleaning and drying the resident to prevent cross-contamination. A separate washcloth should be used for the resident's face and replaced immediately if it becomes soiled. Interview on 06/24/25 at 11:43 AM with Staff F, LPN stated a patient is on enhanced barrier precaution if they have a peg tube, foley catheter or wound. Before entering the patient room, I must make sure I wear a gown, gloves and mask before providing care. I receive education monthly or when there is a new hiring, by the infection preventionist. Interview on 06/24/25 at 12:00 PM with Staff G, LPN stated a patient is on enhanced barrier precaution if they have a peg tube, wound or any open area. Before entering the patient room, I must wash my hands, put on my gown, gloves and mask before providing care. I receive education every day, by the infection preventionist. Interview on 06/24/25 at 04:00 PM with Staff H, CNA stated the residents on Enhanced Barrier Precautions usually have wounds, bedsores, Foley catheters, or PEG tubes. Before I give care, I knock on the door, introduce myself, and make sure I identify the resident. If there's a sign on the door, I get my supplies and put on a yellow gown, gloves, and a mask. I get training on how to properly wear PPE every other week from the staff educator. When I give a bed bath, I change my gloves during the process, use a different washcloth for the face and armpits, and make sure to cover the resident's top half while I wash the lower body. Review of the facility policy and procedure January 2018 regarding Bed Bath of Resident states During the Bed Bath: Cover patient with bath blanket and remove top bed linen (keep patient covered at all times). Remove gown while maintaining dignity. Begin bath in the following order, using a clean part of the washcloth for each 1. Eyes - Wipe from inner to outer canthus, no soap. 2. Face, neck, and ears 3. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Arms and hands - Support joints; include fingernails. 4. Chest and abdomen - Keep female patients covered as much as possible. 5. Legs and feet - Clean toes and heels well. 6. Back and buttocks 7. Perineal area - Use clean gloves; cleanse front to back. Review of the facility policy and procedure August 2014 regarding hand washing/hand hygiene states all personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. Hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub, etc.) shall be readily accessible and convenient for staff use to encourage compliance with hand hygiene policies. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections. Single-use disposable gloves should be used: Before aseptic procedures; When anticipating contact with blood or body fluids; When in contact with a resident, or the equipment or environment of a resident, who is on contact precautions.