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	03/26/2025

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 48906 Based on observations, interviews and record reviews, the facility failed to provide privacy for residents' information on two out of four computer screens on the East side nursing station as evidenced by an observation of an unlocked, unattended computer screen with resident information easily accessible/visible on the east side medication cart #1 and at the East side nursing station. There were 96 residents residing in the facility at the time of the survey. The findings included: 1.On 03/23/25 at 7:39 AM, an observation was made of an unlocked, unattended computer screen on the East side medication cart #1 (photo obtained). On 03/23/25 at 7:41 AM Staff H, Registered Nurse (RN) returned to the medication cart and was asked by the surveyor the protocol for keeping residents' information private on computer screens and replied, I am supposed to lock the screen before I walk away. I was worried about getting the supervisor for you, so I forgot to lock the screen. 2. On 03/23/25 at 8:08, an observation was made of an unlocked, unattended computer screen at the East side nursing station with resident information visible (photo obtained). On 03/23/25 at 8:09 AM Staff M, Licensed Practical Nurse (LPN) was notified by the surveyor about the observation and immediately locked the computer and locked the screen and stated another staff member left it open. (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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of an undated Policy revealed SUBJECT: Patient Privacy DIVISION: Administration DOS Risk Management Services Director DATE: 6/2020 Patient Privacy Policy for Nursing Homes Purpose: The purpose of this policy is to ensure the protection of patient privacy and confidentiality in accordance with applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA) and state-specific regulations. The policy aims to safeguard personal, medical, and financial information of residents in the nursing home, promoting trust, dignity, and respect. Scope: This policy applies to all employees, contractors, volunteers, and other personnel working in the nursing home, including those who handle patient records, communicate with patients, and interact with their families. Definitions: 1.Patient Information: All personally identifiable information (PII) and protected health information (PHI) about residents, including medical, financial, and personal details. 1. Confidentiality: The duty to protect patient information from unauthorized disclosure, access, or use. 2. Protected Health Information (PHI): Any information related to a patient's health condition, treatment, or payment that can be used to identify the patient. 4. Electronic Health Records (EHR): Digital version of a patient's medical history, including their treatment plans, medications, and appointments. Policy Statement 1. Confidentiality and Privacy: a. All patient information must be treated as confidential. Unauthorized access, use, or disclosure of patient information is prohibited. b. Patient information, whether written, electronic, or verbal, should only be disclosed to individuals who have a legitimate need to know, in compliance with legal and regulatory requirements.2. Access to Patient Information: a. Only authorized personnel who require patient information to perform their duties may access PHI. b. Patient information should be stored securely, and access to records must be restricted to those with proper authorization. 4. Electronic and Paper Records: a. Electronic records must be stored in password-protected systems with encryption to prevent unauthorized access. b. Paper records containing PHI should be securely stored in locked areas, and any physical documents that are disposed of should be shredded.

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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31581 Based on observations, record review and interview, the facility failed to ensure the Preadmission Screening and Resident Review (PASARR) Level I was completed accurately prior to admission for three Residents (#50, #83, #60) out of three residents reviewed for PASARR. There were 96 residents residing in the facility at the time of the survey. The findings Included: Record review of the Pre-Admission Screening and Resident Review (PASARR) Policy and Procedure dated 2016 documented: Policy Intent-It is the policy of the facility to assure that all residents admitted to the facility receive a Pre-Admission Screening and Resident Review; Procedure-1) A facility will coordinate assessments with the pre-admission screening and resident review (PASARR) program as stated under Federal Regulations. 1) Observation of Resident #50 on 3/25/25 at 11:07 AM revealed the resident sitting up in bed with the television on. Record review of the Demographic Face Sheet for Resident #50 documented the resident was admitted on [DATE] with diagnoses of diabetes mellitus, hypertension, anxiety disorder, schizophrenia, atrial fibrillation, congestive heart failure and atherosclerosis heart disease. The resident was readmitted to the facility on [DATE]. Review of the PASARR for Resident #50 revealed the PASARR Level I was done on 1/21/25 with no diagnoses of Anxiety Disorder and Schizophrenia checked on the form with documented history. The form documented no PASARR Level II was required. PASARR Level I was completed by a Social Worker at the hospital on 1/21/25. Review of the Minimum Data Set (MDS) 5 Day Assessment for Resident #50 dated 1/28/25 documented the resident's Mental Status (BIMS) Summary Score had a BIMS Summary Score of 00 out of 15 indicating severe cognitive impairment, resident is currently not considered by the state level II PASRR process to have a SMI (Severe Mental Illness) or ID (Intellectual Disability) or a related condition and the resident required substantial/maximal to dependent assistance for ADLs (Activities Daily Living). On 3/26/25 at 7:30 AM, interview with the Admissions Director. She stated, We update the PASARR, when they come here, if it is incorrect. On 3/26/25 at 8:07 AM, interview and record review with the Director of Nursing (DON). She stated, The PASSR was incorrect and should have included the diagnoses for Anxiety Disorder and Schizophrenia. 2) Observation of Resident #83 on 3/25/25 at 11:12 AM revealed the resident sitting up in bed, asleep with a catheter, tube feeding machine off and with the television on. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Demographic Face Sheet for Resident #83 documented the resident was admitted on [DATE] with diagnoses of acute respiratory failure, dementia, shortness of breath, insomnia, alzheimer's disease, hypertension, depression, mood affective disorder and psychosis. Review of the PASARR for Resident #83 revealed the PASARR Level I was done on 12/19/24 with no diagnoses of Psychosis, Depression, and Mood Affective Disorder checked on the form documented history and medications. The form documented no PASSAR Level II was required. PASARR Level I was completed by a Registered Nurse Worker at the hospital on 12/19/24. Review of the Minimum Data Set (MDS) Significant Change Assessment for Resident #83 dated 3/06/25 documented the resident's Mental Status (BIMS) Summary Score had a BIMS Summary Score of 00 out of 15 indicating severe cognitive impairment, resident is currently not considered by the state level II PASARR process to have a SMI or ID or a related condition and the resident required partial/moderate to dependent assistance for ADLs (Activities Daily Living). Review of the Physician's Order Sheet (POS) for February 2025 and March 2025 for Resident #83 documented the resident received Quetiapine Fumarate Oral Tablet 25 MG (milligrams) Give 1 tablet via PEG-Tube at bedtime for psychosis and Escitalopram Oxalate Oral Tablet 10 MG Give 1 tablet via PEG-Tube in the morning for psychosis. Review of the Care Plans for Resident #83, written 12/19/24 documented the resident received antipsychotic medications. On 3/25/25 at 7:54 AM, interview with the Social Services Assistant. She stated, The Admissions Office checks the PASARRs. On 3/26/25 at 8:08 AM, interview and record review with Director of Nursing (DON). She stated, The PASARR was incorrect and should have included the diagnoses for Psychosis, Depression and Mood Affective Disorder. 48906 3) On 03/23/25 at 10:57 AM while sitting in the dining area, the surveyor overheard yelling in the hallway. The surveyor observed Resdient #60 standing in the doorway yelling. Multiple staff members were observed speaking to Resident#60 in a calm manner however Resident #60 continued to yell. Minutes later, Resident #60 agreed to sit in a chair in the doorway of the room. Record review of a demographic sheet for Resdient #60 revealed an admitted [DATE] and a readmitted [DATE] with diagnoses that included: Depression, Psychotic Disorder with Delusions due to Known Psychological condition, schizoaffective disorder. Record review of an Annual Minimum Data Set reference dated 3/19/25 revealed A1500. Preadmission Screening and Resident Review (PASRR), Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? - No. Section I revealed Schizophrenia, Depression (other than bipolar), Section N-Antidepressant and Section O- E. Psychological Therapy, E1. Total minutes - record the total number of minutes this therapy was administered to the resident in the last 7 days- 0. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Care Plan initiated on 12/04/2024 and revised on 12/19/2024 revealed Resident #60 was noted with physically aggressive behaviors, had a goal to demonstrate effective coping skills through the review date. (Target Date: 03/16/2025) and interventions included: When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later and Psychiatric/Psychogeriatric consult as indicated. Record review of a physician's order sheet revealed orders dated 2/7/24 to monitor for side effects r/t (related to) psychotropic med use and 7/10/24 to Trazodone Hydrochloride Oral Tablet 50 milligrams directions: Give 1 tablet by mouth at bedtime related to Depression. Record review of a PASARR Level 1 dated 6/2/23 revealed Section I: PASARR Screen Decision- Making A. MI or suspected MI (check all that apply): no diagnosis was checked. The surveyor requested the most recent PASARR from the Director of Nursing (DON). The Nursing Home Administrator presented the surveyor with a PASARR for Resident #60, dated 3/22/22, Section I: PASARR Screen Decision- Making A. MI or suspected MI (check all that apply): no diagnosis was checked. Interview with the Nursing Supervisor stated, Resident #60 was seen by Psychiatry yesterday and I will complete a new PASARR. The Nursing Supervisor presented a PASRR for Resident#60, dated 3/25/25 to Surveyor which revealed: Section I: PASRR Screen Decision- Making A. MI or suspected MI (check all that apply): Anxiety, Depressive disorder was checked. On 3/26/25 the DON presented the Surveyor with a Progress note written by the Psychiatrist dated 3/25/25. The progress note revealed a diagnosis that included: Schizophrenia. On 3/26/25, the Director of Admission and the Director of Nursing were interviewed about the PASRR process. The Director of Admissions stated, Upon admission I work with the Social workers in the hospitals prior to admission, to gather the clinicals and a completed PASARR. Sometimes the PASARRs are incomplete, and the diagnoses don't reflect the current medications the residents are taking. In this instance, I refer to the DON. The PASARR is used to make sure the resident is in the right setting due to any cognitive impairment or mental illness. If the resident is transferred to the hospital and returns in less than 30 days it is not required to update the PASARR. When Resident #60 was admitted there was no medication for depression and that is why no diagnoses were checked. On 3/26/25 the DON stated, When residents are admitted I review the medications and the history to make sure it is correctly reflected on the PASARR. We review the PASARRs monthly and/or when there is a change in behavior. PASARRs are also discussed in the morning meeting and the social worker is made aware and any new changes are care planned. We also get a psychiatric or psychologist consult for the resident. The PASARR for Resident #60 should have been updated at the time the antidepressant was prescribed to reflect all current mental illness diagnoses. The Psychiatrist evaluated Resident #60 yesterday (3/25/25) due to Resident #60 exhibiting increased anxiety and prescribed a new medication. Resident #60 is typically quiet, requires redirection and that is effective. Record review of a Policy and Procedure titled, Subject: Pre-Admission Screening and Resident Review (PASARR) Program revealed: DATE: 2016 (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	INTENT: It is the policy of the facility to assure that all residents admitted to the facility receive a Pre-Admission Screening and Resident Review, in accordance with State and Federal Regulations. DEFINITIONS: For purposes of this Policy: 1. An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b) (1). 2. An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in S483.102(b) (3) or is a person with a related condition as described in 435.1010 of this chapter. S483.20(k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review. PROCEDURE: 1. A facility will coordinate assessments with the pre-admission screening and resident review (PASARR) program as stated under Federal Regulations to the maximum extent practicable to avoid duplicative testing and effort. Coordination 1. Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. 2. Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status 2. The facility will not admit, on or after January 1, 1989, any new residents with: A. Mental disorder, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to: i. That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and ii. If the individual requires such level of services, whether the individual requires specialized services; or (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. Intellectual disability, as unless the State intellectual disability or developmental disability authority has determined prior to admission: i. That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and ii. If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. 3. Exceptions. For purposes of this requirement include: 1. The preadmission screening program under paragraph(k)(1) of the regulation need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. 2. The State may choose not to apply the preadmission screening program under paragraph (k)(1) of the regulation to the admission to a nursing facility of an individual: Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, Who requires nursing facility services for the condition for which the individual received care in the hospital, and iii. Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. 4. Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If the facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 48906 Based on observation, interviews, and record review, the facility failed to develop and implement comprehensive care plans for Residents #43, #74 and #291 as evidenced by no comprehensive care plan with interventions for floor mats for one resident (#291), no implementation of a fall care plan for one resident (#74) out of 6 residents who use floor mats and no care plan for a neck brace for one (#43) out of two residents who require neck braces. There were 96 residents residing in the facility at the time of the survey. The findings included: 1. On 3/23/25 at 7:54 AM Resident#291 was observed in bed with one floor mat on the resident's right side, a call light was in reach. Another observation on 03/25/25 08:53 AM revealed bilateral floor mats were in place for Resident #291. Record review of a demographic sheet for Resident #291 revealed an admitted [DATE] with diagnoses that included: Syncope and Collapse, Muscle Wasting and Atrophy. Record review of an admission Minimum data set (MDS) reference dated 3/8/25 revealed Resident #291 had a Brief Interview of Mental Status (BIMS) score of 9, indicated moderate cognitive impairment and required supervision or touching assistance for rolling left and right and partial/moderate assistance for Sit to stand, transfer and walking 10 feet. Record review of a Care Plan initiated on 03/23/2025 and revised on 03/23/2025 revealed Resident #291 was at risk for falls and had no interventions pertaining to floor mats. Record review of Resident #291's current physician order sheet revealed no current orders for floor mats. On 3/25/25 at 11:45 AM, Staff H, Registered Nurse (RN) was interviewed about how many floor mats are required for Resdient #291 and stated, I was the nurse on Sunday and there was only one floor mat present on the Resident #291's left side because the resident usually gets out on that side of the bed. On 3/25/25 at 1:58 PM The MDS Coordinator stated, The floor mats had not been care planned until today for Resident #291. 2. On 03/23/25 at 9:53 AM Resident#74 was observed in bed, no distress, appears confused, bed low, call light in reach, one floor mat on the right side of resident. Staff N, LPN was asked how many floor mats are to be present and replied, I will check and get back to you. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a demographic sheet for Resident#74 revealed an admitted [DATE] with diagnoses that included: Muscle wasting and Atrophy right upper arm, Right and Left Lower Leg, and Difficulty in walking. Record review of a Quarterly Minimum data set (MDS) reference dated 1/28/25 revealed Resident#74 had a Brief Interview of Mental Status (BIMS) of score 00, indicated severe cognitive impairment, uses walker and wheelchair, required partial/moderate assistance for walking and transfer. Record review of a care plan initiated on 02/01/2025 and revised on 02/01/2025 revealed Resident#74 was at risk for falls and had interventions that included: Provide bilateral floor mats for falls precautions and safety. Record review of a physician order sheet for Resident#74 revealed no orders for floor mats. Interview on 3/25/25 at 11:02 AM Staff N, Licensed Practical Nurse (LPN) stated, I am the nurse assigned to R#74 today. This resident is under fall precautions. One intervention is the floor mat on the right side of the resident because this is the side he usually tries to get up from the bed. I have observed this resident sitting on the right side of the bed. He can walk short distances with assistance and uses a wheelchair. The floor mat is used for safety precautions. This resident is to have one floor mat. On 3/25/25 at 1:34 PM the MDS Coordinator nurse presented the surveyor with a revised care plan for at risk of falls with a revised intervention dated 3/25/25: Provide right floor mats for falls precautions and safety. On 3/25/25 at 1:58 PM the MDS Coordinator stated, I am in charge of completing and updating care plans in conjunction with the nursing staff. The Restorative nurse communicates with me for residents who require floor mats for fall precaution. R#74's care plan was revised today (3/25/25) to reflect an intervention from bilateral floor mats to one floor mat on the right side. This intervention started over the weekend. On 3/26/25 at 8:24 AM the Restorative/ wound care nurse stated, Upon admission if a resident has a history of fall we put them in a fall program that includes close monitoring for 30 days, a low bed, and floor mat. The amount of floor mats are determined by the side the resident is observed trying to get out the bed without assistance. Sometimes it can be both sides. Resident #74 and #291 are not able to walk independently. We don't need a physician's order to implement floor mats. The floor mats are care planned. The floor mats were implemented for Resident #291 on the weekend due to observations by staff of Resident #291 trying to get out of bed. I told staff to place one floor mat on the side of the window. I informed MDS on Tuesday, 3/25/25. On 3/26/25 at 11:44am the Director of Nursing (DON) was interviewed by the surveyor about care planning concerns for floor mats. The DON stated there is a 24 hour report in the electronic health record where staff can check the updated status of residents. No order is required for floor mats but should be care planned. There is also a binder kept at the nursing stations that contain residents' who require floor mats. The Restorative nurse updates that binder. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a Policy titled Comprehensive Care Plans DATE: 2010 REVISED: 12/2016, 3/2020 revealed DEPARTMENT: Nursing INTENT: It is the policy of the facility to promote seamless interdisciplinary care for our residents by utilizing the interdisciplinary plan of care based on assessment, planning, treatment, service and intervention. It is utilized to plan for and manage resident care as evidenced by documentation from admission through discharge for each resident. Every resident will have an Interdisciplinary Care Plan, with the Interim Interdisciplinary Care Plan initiated within 24 hours of admission. The care plan will identify priority problems and needs to be addressed by the interdisciplinary team, and will reflect the resident's strengths, limitations and goals. The care plan will be complete, current, realistic, time specific and appropriate to the individual needs for each resident. There will be ongoing documentation of the nursing process related to resident needs from admission to discharge. The interdisciplinary plan of care will be developed through collaborative efforts of the Interdisciplinary Team and other health care professionals. It will be consistent with the medical plan of care and those disciplines that have direct involvement with the resident's care. The resident and/or family member will be involved in the care planning. The care plan will contain information about the physical, emotional/psychological, psychosocial, spiritual, educational and environmental needs as appropriate. Developing the Care Plan: 1. The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. 2. The comprehensive care plan will describe the following: b. Any services that would otherwise be required per regulation but are not provided due to the resident's exercise of rights, including the right to refuse treatment. Updating Care Plans: 1. Care plans are modified between care plan conference when appropriate to meet the resident's current needs, problems and goals. 3. The Care Plan will be updated and/or revised for the following reasons: d. A change in planned interventions; 51537 3) In an observation conducted on 03/23/2025 at 06:51 AM revealed, resident #43 lying in bed and stated that she was feeling tired. There were no visible signs of distress or discomfort at the time of observation. Her environment appeared to be calm, and no immediate concerns were noted. Observation of resident # 43 on 03/24/2025 at 09:11 AM. The resident was observed lying in bed the head of the bed was raised, and the resident stated she was tired. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of resident # 43 on 03/24/2025 at 01:14 PM. The resident was lying in bed, speaking very disoriented. Record review revealed Resident # 43 was originally admitted to the facility on [DATE]. Resident #43 diagnoses included Parkinson's disease without dyskinesia, without mention of fluctuations. Review of the physician's orders dated 8/20/2024 11:00pm Revision: 11/18/2024 revealed the resident must Keep C-collar in place at all times. Remove during care and inspect skin call MD if any abnormalities every shift. Record review of Resident # 43 Admission Minimum Data Set (MDS) Section C Cognitive Pattern in the Brief Interview for Mental Status (BIMS) documented 00 out of 15. Section G for functional status indicated the resident needs Supervisor/Touching Assistance for activities of daily living (ADL). The facility did not have a care plan for the use of the C-collar. Interview with Staff K, Registered Nurse (RN) on 03/25/25 at 9:14 AM revealed upon record review that the C-collar was to always kept in place, at this moment she proceeded to have the surveyor speak to restorative services for further information. Interview with the Physical Therapy Assistant (PTA) on 03/25/25 at 09:38AM revealed the resident is not doing therapy at this time, she revealed the resident is in a restorative program doing exercise and the surveyor needed to speak with someone from restorative. Interview with Staff G, Restorative Certified Nursing Assistant (CNA) on 03/25/25 at 10:05 AM revealed the resident was supposed to wear the C-collar constantly, but that normally she doesn't like to sleep in it, or wear it in the dining room, she also mentioned they continue to educate her of the importance of her wearing the C-collar. When the surveyor asked where the C-collar is now, the restorative aide revealed it is in the laundry, she stated the sponge is wet at the moment, but they will finish drying it and would place it back on the resident. Interview with DON on 03/26/25 at 02:14 PM revealed about the frequency of staff monitoring resident # 43, the DON responded that every 2 hours, the DON also mentioned the resident had been participating in a fall prevention program. Furthermore, she stated that in November 2024 Resident # 43 had a CT (Computed Tomography) scan for further evaluation, and the results were sent to the neurologist for reevaluation of the removal of the C-collar and no new order were received. Record review of the facility's policy and procedure to follow physicians order. Effective date 2005/Revised 2021 under Policy: The purpose is to ensure that residents receive care and services in timely a manner when orders are given by their Physicians. Policy 1. Physician orders will be followed as prescribed. If not followed, reason will be documented in Residents medical records.

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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** 48906 Based on observations, interviews and record review, the facility failed to provide supervision to prevent safety hazards for one resident (#2) out of 32 sampled residents as evidenced by an observation of an electrical cord plugged into an outlet suspended in the air in such a way that caused a tripping hazard in the room of Resident#2. There were 96 residents residing in the facility at the time of the survey. The findings included: On 03/23/25 at 9:44 AM an observation was made of an electrical cord for the air mattress wrapped around the side table, extending and suspended in the air, which caused a tripping hazard in the room of Resident #2. Staff H, Registered Nurse (RN) was present in the room at the time of the observation and was notified by the surveyor of the potential tripping hazard. Staff H, RN readjusted the plug behind the bed. On 03/25/25 at 12:18 PM the Nursing Home Administrator (NHA) was made aware by the surveyor about the tripping hazard observation and stated, Electrical cords should be behind the bed and plugged into the wall unit to avoid a tripping hazard. On 03/25/25 at 3:00 PM the NHA informed the surveyor that all plugs are now zip tied to the bed frame to prevent any tripping hazard. The NHA showed the surveyor a picture that revealed the electrical cord was zip tied around the bed frame. Record review of a demographic sheet for Resident #2 revealed an admitted [DATE] and a readmitted [DATE] with diagnoses that included: Acute Respiratory Failure with Hypoxia and Covid-19. Record review of a significant change in status Minimum data set (MDS) reference dated 2/24/25 revealed Resident#2 had a Brief Interview of Mental Status (BIMS) score of 12, indicating moderate cognitive impairment, no potential indicators of Psychosis, was dependent on staff for Chair/bed-to-chair transfer and no falls since Admission/Entry or Reentry or Prior Assessment. Record review of a Care Plan initiated on 09/25/2023 and revised on 09/25/2023 revealed Resident#2 was at risk for falls related to Monoplegia of right dominant side, muscle weakness and had interventions that included: Follow facility fall protocol. Record review of physician order sheet revealed an order dated 3/23/25 for Low air loss mattress in place as preventative measures and to promote wound healing. Check for proper functioning every shift. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the policy (undated) titled, Miami [NAME] Nursing and Rehabilitation Safety and Supervision of Residents: revealed a Policy Statement: Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Policy Interpretation and Implementation. Facility-Oriented Approach to Safety 4. Employees shall be trained and in serviced on potential accident hazards and how to identify and report accident hazards, and try to prevent avoidable accidents. Resident Risks and Environmental Hazards 1. Due to their complexity and scope, certain resident risk factors and environmental hazards are addressed in dedicated policies and procedures. These risk factors and environmental hazards include: Electrical Safety.

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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** 48906 Based on observations, interviews and record review, the facility failed to provide appropriate treatment and services for catheter care for one (Resident #2) out of one resident who has a suprapubic catheter as evidenced by observations of the urinary catheter tubing being kinked, and touching the floor. There were 96 residents residing in the facility at the time of the survey. The findings included: On 03/23/25 at 9:35 AM Resident #2 was observed in bed with oxygen in progress at 2Liters per minute via a nasal cannula and no apparent distress was noted. A urinary catheter tubing was observed kinking in a circle and the urine was not properly draining (photo obtained). Staff H, Registered Nurse (RN) was present in the room and was notified by the surveyor about the kinking of the tubing. Staff H, RN then straightened out the tubing to allow free flow of urine. Staff H, RN was asked by the surveyor the correct way to position the tubing and Staff H stated, I round every morning and check the catheter tubing. This morning, I found the night nurse was working with the indwelling catheter, so I didn't notice it was kinked. On 03/24/25 at 7:38 AM Resident #2 was observed in bed with oxygen in progress at 2 Liters per minute via a nasal cannula, no apparent distress was noted. The urinary catheter tubing was observed touching the floor (photo obtained). On 03/24/25 07:42 AM Staff N, Licensed Practical Nurse (LPN) stated, I did a double and when I rounded this morning, and I checked on Resident #2. At that time the indwelling catheter tubing was not touching the floor. It appears the reason it was touching the floor was because someone lowered the bed too low. I round every two hours and as needed to make sure the proper interventions are in place. I communicate with the Certified Nursing Assistant (CNA) about required interventions for catheter care and I will reinforce. On 03/24/25 at 7:53 AM Staff P, CNA stated, I am the CNA taking care of Resident #2 today. I have received in-services on catheter care and the nurse speaks to me about catheter care. I empty the collection bag and record the amount. I don't allow the collection bag to touch the floor. I also make sure it is anchored to the bed. I made rounds this morning and the tubing was not touching the ground and I did not lower the bed. The bed should not be too low because the tubing or bag might touch the ground for infection control purposes. On 03/24/25 at 8:10 AM the Nursing educator advised the surveyor that the Indwelling urinary catheter system was changed. Record review of a demographic sheet for Resident#2 revealed an admitted [DATE] and a readmitted [DATE] with a diagnosis that included Reflex Neuropathic Bladder. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a significant change in status Minimum data set (MDS) reference dated 2/24/25 revealed Resident#2 had a Brief Interview of Mental Status (BIMS) score of 12, indicated moderate cognitive impairment, was dependent on staff for personal hygiene care, had indwelling catheter, and Neurogenic bladder, Obstructive uropathy. Record review of a Care Plan initiated on 11/01/2024 and revised on 03/07/2025 revealed Resident #2 had a suprapubic catheter related to obstructive uropathy and is at risk for complication with goals that included: be free of any s/s of infection through review date and interventions that included: Check tubing for kinks each shifts, Check catheter bag for any leakage and change as needed. Record review of the physician order sheet revealed an order dated 3/23/25 for 3/19/25-Foley catheter care every shift and as needed, Change Foley bag weekly every night shift every Sunday Change Foley catheter (16)FR every night shift every 1 month(s) starting on the last day of month for 1 day(s). On 03/25/25 01:58 PM Staff N, LPN was asked if this resident#2 has a suprapubic catheter? and Staff N replied, No. On 3/25/25 at 2:15 PM Staff S, Nursing supervisor approached the surveyor and revealed Resdient #2 had a suprapubic catheter. On 03/26/25 at 8:48 AM Staff N, LPN was reinterviewed and stated, Resident #2 has a suprapubic catheter. I thought it was an indwelling urinary (urethral) catheter because that is what this resident had before he went out to the hospital. I didn't know it was changed to a suprapubic catheter. I usually only empty the collection bag. After I spoke to you, I completed a skin check and realized there was a suprapubic catheter in place. On 03/26/25 at 11:44 AM the Director of Nursing (DON) was made aware of the catheter concerns and asked about procedures and protocols when providing catheter care and stated, Staff are to monitor the catheter to make sure the urine is draining properly, catheter tubing is not kinked or touching the floor. Also stated, The physician orders pertaining to catheter care for Resident #2 should have included suprapubic instead of Foley and they were updated on 3/25/25. Record review of a Policy titled, Urinary Catheter Care written: 4/01/2009 revision date: 9/14/2012, 01/12/2014 revealed: POLICY/PROCEDURE: The purpose of this procedure is to prevent infection of the resident's urinary tract. STEPS: 10. Secure catheter and check drainage tubing and bag to ensure that the catheter is draining properly.

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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. 51065 Based on observations, interviews and record reviews, the facility failed to properly store medications as evidenced by an observation of a box of expired Rapid Antigen (Covid-19) test kits in one medication storage room and an unlocked cart (cart #1) on the west wing unit, and an unattended medication at the bedside for resident #2. The Findings included: 1) Accompanied by Staff S, an observation of the [NAME] Wing medication storage room was conducted on 03/23/2025 at 09:50 AM. The observation revealed a box with multiple expired Covid-19 test kits inside the bottom cabinet. Each Covid-19 test kit was observed with an expiration date of 01/30/2024. Staff S, Registered Nurse (RN) supervisor confirmed the expiration date and removed a box of multiple expired Covid-19 test kits. On 03/26/2025 at 02:58 PM, Staff S stated: The nursing supervisors are the ones in charge of monitoring and checking the medication storage room each shift. The supervisor from each shift is responsible of checking the crash cart, med room, and the pantry. When we find something or medication expired, we package it and return to pharmacy. If there is a medication that is expired in the med cart, we remove it right away and place it in the return bin for the DON (Director of Nurses) to waste it with the pharmacy. We are also supposed to place a sign on the box when it is expired, stating it cannot be used. To my understanding, a nurse cannot use a covid test without checking the expiration date first. We usually always have in-services regarding how long we are supposed to use, for example, the lancets, eye drops, solution for Accu-Check, covid tests, over the counter meds and where to look for the expiration date. Prior to administering medication, we are always supposed to check the expiration. We also have to label the Accu-Chek solution with the date it was opened and the date of expiration. On 03/26/2025 at 03:10 PM the Director of Nursing (DON) stated: The nursing supervisor and DON checks the medication storage rooms daily. If there are any supplies that are expired, we discard immediately. The expired covid test that you found, can still be used because there is an extended expiration date. It is stated in the FDA (Food and Drug Administration) website. The OHC (Healthcare) Antigen self-tests were the ones that were expired. 48906 2) On 03/23/25 at 7:21 AM the surveyor was walking in the hallway, and an observation was made of the an unlocked medication cart (cart #1) on the [NAME] side nursing station. Staff U, Registered Nurse (RN) approached the medication cart and was asked by the surveyor about the protocol for medication storage. Staff U, RN replied, The medication cart should be locked when I walk away from it, but I forgot because I was moving quickly to assist residents. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3) On 03/23/25 at 9:35 AM the Surveyor entered the room of Resident #2. Staff H, RN was observed attempting to flush a feeding tube for Resient#2 to administer medication. Staff H was unable to flush the tube and told the surveyor that she would leave the room to retrieve an item to assist with the procedure. Staff H, RN exited the room. There was a cup of crushed medication mixed in water on the side table and a glucometer with a lancet on the side of the sink (photo obtained). On 03/23/25 at 10:33 AM Staff H, RN returned and was asked by the surveyor about the protocol for leaving medications. Staff H replied, I left the medication and glucometer with the lancet in the room because you (surveyor) were present. The proper protocol is to take the medications and materials with me. On 03/26/25 11:44 AM the DON and Nursing Home Administrator were informed of the observation and stated, The nurse didn't know she could not leave medications unattended. Record review of a Policy and Procedure titled, Medication Storage dated 2001 MED-PASS, Inc. (Revised April 2007) revealed a Policy Statement: The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. Policy Interpretation and Implementation: 2. The nursing staff shall be responsible for maintaining medication storage AND preparation areas in a clean, safe, and sanitary manner. 4. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed. 7. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others. 8. Drugs shall be stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Each resident's medications shall be assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medications of several residents.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 31581 Based on observation, interview, and policy review, the facility failed to assure cardboard boxes were properly disposed and contained on the facility grounds. Cardboard boxes were scattered on the ground outside the kitchen back door. The findings included: Record review of the Food-Related Garbage and Rubbish Disposal Policy and Procedure revised 4/2024 documented: Policy Statement-Food-related garbage and rubbish shall be disposed of in accordance with current state laws regulating such matters; Policy Interpretation and Implementation-4) Food storage boxes/containers will be disposed of by the end of each shift into the outside dumpsters. Observation of the outside of the facility at the kitchen back door with the Dietary Aide A on 3/23/25 at 7:01 AM. There were multiple cardboard boxes on the ground and not contained in the garbage bin. Photographic evidence submitted. On 3/23/25 at 7:03 AM, interview with Staff A, Dietary Aide. She stated, Someone is supposed to break down the cardboard boxes and take them to the garbage container. They should not be on the ground. On 3/23/25 at 8:27 AM, interview with the Dietary Director. He revealed that the carboard boxes were removed from the ground outside of the kitchen back door and should not have been on the ground.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31581 Based on observation, record review and interviews, the facility failed to ensure residents' medical records are accurate in accordance with accepted professional standards and practices for one (Resident #33) out of one resident sampled, as evidenced by a Nurses' Progress Note for Resident#33 documented the resident was COVID 19 positive and the resident was COVID 19 negative. These practices has the potential to affect any of the residents residing in the facility. The findings included: Record review of the Charting and Documentation Policy and Procedure revised 03/2024 documented: Policy Statement-All services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record; Policy Interpretation and Implementation-1) All observations, medications administered, services performed must be documented in the resident's clinical record; 2) Entries may only be recorded in the resident's clinical record by licensed personnel (Registered Nurse, Licensed Practical Nurse, Physician, Therapists). Review of the Charting Errors and/or Omissions Policy and Procedure revised 03/2024 documented: Policy Statement-Accurate medical records shall be maintained by this facility; Policy Interpretation and Implementation-1) If an error is made while recording the data in the medical record, Staff member will be added to the medical record as an error. Review of the Demographic Face Sheet for Resident #33 documented the resident was admitted on [DATE] with diagnoses that included but not limited to chronic obstructive pulmonary disease, diabetes mellitus, hypertension, acute kidney failure, protein-calorie malnutrition and atherosclerotic heart disease. Review of the Minimum Data Set (MDS) Quarterly assessment dated [DATE] for Resident #33 documented the resident's Brief Interview of Mental Status (BIMS) Summary Score was 00, indicating severe cognitive impairment and required dependent assistance for ADLs (activities daily living). Review of the Nurses' Progress Notes for Resident #33 dated 3/24/2025 at 06:48 documented: Resident remaining in droplet/contact precaution for COVID 19 positive results using z pack in this moment asymptomatic with positive improvement. Review of the Physician's Order Sheets (POS) and Medication Administration Records (MAR) for March 2025 documented the resident was not receiving antibiotics or a Z pack (Azithromycin). On 3/26/25 at 8:04 AM during an interview and record review, with the Director of Nursing (DON) it was stated, He does not have COVID. He does not receive any antibiotics such as Z pack. The progress note is inaccurate. On 3/26/25 at 9:59 AM during an interview with Staff B, Licensed Practical Nurse (LPN) revealed that the resident is not COVID positive.

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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. 51537 Based on interview and record review, the facility failed to demonstrate effective plans of actions were implemented to correctly identify quality deficiencies in the problem area related to repeated deficient practices for F880 Infection Prevention & Control, as evidenced by the infection control protocol was not followed on the east side soiled utility room and failed to follow infection control protocol for one Resident # 57, as evidenced by a failure to implement hand hygiene. There were 96 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 survey with exit dated October 19, 2023, F880 Infection Prevention & Control was cited related to the fact that the facility failed to implement infection control procedures for three (Residents 89, 347, 348) out of 28 sampled residents. Interview with the Director of Nursing (DON) on 03/26/25 at 03:44 PM. She stated that the Quality Assurance and Performance Improvement (QAPI) meetings are held each month. She stated that QAPI committee members are Medical Director, Administrator, Director of Nursing, Social Services, Business Office Manager, Dietary, MDS (Minimum Data Set), and Wound Care. She stated that they have daily meetings, and monthly recap meetings. They started reviewing the last meeting and focusing on the deficiencies the facility had in the last survey. She stated the way they monitor Quality Assurance is to continuously communicate with the different departments and make sure we track the corrective actions implemented. They also provide in-service education and regular performance review. She said staff addresses any concerns to their supervisor. Residents with weight issue get weighed weekly, if residents are not eating they have a team put a plan into place. When asked about staffing, she revealed they met the state requirements and they have increased supervision 7:00am-7:00pm. Record review of Quality Assurance/Quality Assurance Performance Improvement QAPI/QAA 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. [.] has a Performance Improvement Program which systematically monitors, analyses 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. We will monitor our operations for compliance with federal and state regulations.

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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** 51356 Based on observation, record review and interviews, the facility failed to follow their infection control protocol in the East side soiled utility room and with Resident's #2 and #57. This is evidenced by trash and food observations on the floor inside the resident's pantry room on the East side nursing station, Resident #2 indwelling catheter tube touching floor, staff not wearing proper personal protective equipment (PPE) when entering droplet precaution rooms during meal tray distribution and Improper hand hygiene during wound care. There were 96 residents residing at the facility at the time of the survey. The findings included: 1) On 03/23/25 at 07:51 AM, Staff were observed not wearing PPE while entering a contact/droplet resident room while distributing breakfast trays. 2) On 03/25/25 at 11:02 AM, observation of Wound Care. The Wound Care Nurse gathered supplies that consist of kerlix, normal saline, collagen, tape, 4 x 4 gauze, scissors, red bag and chuck pads. The Wound Care Nurse locked the computer and cart, knocked on the residents' door, provided privacy, washed hands, applied gown and double gloves. The old dressing dated 03/23/25. The Wound Care Nurse removed the old dressing and one pair of gloves. The Wound Care Nurse sanitized the gloves and applied a new pair of gloves. The Wound Care Nurse cleaned the wound, removed one pair of gloves and applied another pair of gloves. The Wound Care Nurse placed collagen power and 4 x 4 gauze on the wound, wrapped the kerlix and dated the tape on the wound. The Wound Care Nurse removed the gloves, gown, washed hands, throwed the red bag in biohazardous bin in the biohazard room, washed hands and signed off on treatment record. Review of the medical records for Resident #57 revealed the resident was admitted to the facility on [DATE]. Clinical diagnoses included but were not limited to: Unspecified open wound, right lower leg, initial encounter. Review of the Physician's Orders Sheet on 03/24/2025 revealed that Resident #57 had an order for Collagen-Antimicrobial External Sheet (Collagen-Antimicrobial) Apply to Left lateral leg topically every day shift every other day for Surgical Wound Cleanse left lateral leg with normal saline, pat dry, apply Ag collagen sheet cover with 4x4 and wrap with kerlix every other day and as needed until resolved and Apply to Left lateral leg topically as needed for Surgical Wound Cleanse left lateral leg with normal saline, pat dry, apply Ag collagen sheet cover with 4x4 and wrap with kerlix every other day and as needed until resolved. Review of the Physician's Orders Sheet on 03/11/2025 revealed that Resident #57 had an order to Offload bilateral heels with pillows while in bed as tolerated, every shift. Review of the Physician's Orders Sheet on 02/20/2025 revealed that Resident #57 had an order for a Geriatric air mattress in place to promote wound healing and as preventative measures. Check for proper functioning every shift. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Physician's Orders Sheet on 01/06/2025 revealed that Resident #57 had an order to Turn and reposition every (q) 2 hours (hrs) and as needed, every shift. Record review of Resident #57's Minimum Data Set (MDS) dated [DATE] revealed: Section C for Cognitive Patterns documented a Brief Interview for Mental Status (BIMS) Score of 15, on a 0-15 scale indicating the resident is cognitively intact. Section GG for Functional Abilities documented the resident is dependent on toileting, showering, upper and lower body dressing. Section H for Bowel and Bladder documented Resident #57 is always incontinent. Section J for Health Conditions documented no falls since admission. 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. Section M for Skin Conditions documented diabetic foot ulcers and pressure injury device for bed. Record review of Resident #57's Care Plans revealed the resident has a diabetic ulcer of the right lateral lower leg and is at risk for complication. Interventions include- Geriatric air mattress in place to promote wound healing and as preventative measures. Check for proper functioning every shift. Monitor Blood Sugar Levels. Monitor pressure areas for color, sensation, temperature. Interview on 03/25/25 at 11:23 AM with the Wound Care Nurse it was stated she has been the wound care nurse at this facility since 2022. The measurements for the wound on 3/13/25 were 6.2x4.7x0.2 cm and it is improving but the resident is non-compliant and refuses treatment or medications. The Resident has diabetes that slow down wound healing process. She has supplements like multivitamin for hair, skin and nails. The Resident is on enhanced barrier precautions for the open wound. The Resident has pain management and receives Percocet and Tylenol around the clock. The Resident has orders for an air mattress for offloading, pillow offloading, turn and reposition every 2 hours, bunny boots and weekly skin checks by nurses. The protocol for the new resident would be doing a skin integrity assessment form. She would fill out the form with the residents' information, do a head-to-toe assessment, document and if they have a wound, she would asses the wounds and call whichever doctor is responsible. I would ask the doctor what to order for the patient, insert the orders and make a note. There is a log for residents with wounds on admission and initial treatment. The Wound Care Nurse states she would put an order for an air mattress if required and call the family to explain what was found. The podiatrist comes every Thursday. The podiatrist sees patients with wounds from the knee down and the wound doctor see patients hip and up. The wound doctor comes on Tuesday's. The Wound Care Nurse states she rounds with the doctors. The surveyor asked the Wound Care Nurse why she used doubled gloves during the care and she stated it is within the protocol and she has doubled gloved during wound care observations in the past with the Agency for Healthcare Administration (AHCA) and they have been okay with it. 3) Interview on 03/26/25 at 12:54 PM with Staff H, Registered Nurse (RN) stated before entering the room, I fully apply PPE before going inside. Gown, gloves and mask. I received education about infection control and handwashing by Staff T, RN. The staff test for covid almost every day and a staff nurse does it. The residents stay isolated. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 03/26/25 at 12:30 PM with Staff I, Licensed Practical Nurse (LPN) stated, I have been a nurse at the facility for [AGE] years. Before entering a residents room, the staff should put on PPE which consist of gloves, gown and mask. As a nurse, I would only test residents if they have signs or symptoms of covid. After the resident is positive, they should have 3 negative tests to be taken off isolation. I have received education about handwashing and infection control by a supervisor or Staff T, RN. Interview on 03/26/25 at 02:20 PM with Staff J, LPN it was stated before entering a residents room that is covid positive, I would put on my PPE. I received education on handwashing and infection control almost everyday by Staff T, RN. The supervisors test the residents to see if they are still are positive and they stay in isolation. Interview on 03/26/25 at 01:58 PM with DON it was stated I have been the DON at the facility for 2 months. Staff should perform hand hygiene when they encounter residents rooms, handling soiled linen or handling and passing out trays. Staff receive education monthly, have surveillance and on spot teaching by Staff T, RN. Staff should not double glove when giving care to residents. Staff should throw away gloves and wash hands. Interview on 03/26/25 at 01:09 PM with Staff E, Certified Nursing Assistant (CNA) stated I have been a CNA at the facility for one year. If a resident is covid positive I would put on mask, gown and gloves before entering the room. I have received education on infection control and hand washing, last year by Staff T, RN. I would wash my hands before feeding resident's, giving care, after taking out garbage, laundry and before passing food trays. Interview on 03/26/25 at 01:15 PM with Staff F, CNA stated I have been a CNA at the facility for [AGE] years. If a resident is covid positive I would wear a gown, glove, hat and mask before entering the room. I have received education on infection control and hand washing, yesterday by Staff T, RN. Interview on 03/26/25 at 01:24 PM with Staff G, CNA stated she has been a CNA at facility for [AGE] years. If the resident was covid positive, I would clean my hands, knock, apply gown, gloves, mask and shield for droplet precautions. My last education on infection control and handwashing was given a month ago by Staff T, RN. 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. 48906 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	03/24/25 07:42 AM Staff N, Licensed Practical Nurse (LPN) stated, I did a double and when I rounded this morning, and I checked on Resident#2. At that time the indwelling catheter tubing was not touching the floor. It appears the reason it was touching the floor was because someone lowered the bed too low. I round every two hours and as needed to make sure the proper interventions are in place. I communicate with the Certified Nursing Assistant (CNA) about required interventions for catheter care and I will reinforce. 03/24/25 at 7:53 AM Staff P, CNA stated, I am the CNA taking care of Resident#2 today. I have received in-services catheter care and the nurse speaks to me about catheter care. I empty the collection bag and record the amount. I don't allow the collection bag to touch the floor. I also make sure it is anchored to the bed. I made rounds this morning and the tubing was not touching the ground and I did not lower the bed. The bed should not be too low because the tubing or bag might touch the ground for infection control purposes. On 03/24/25 at 8:10 AM the Nursing educator advised the surveyor that the Indwelling urinary catheter system was changed. On 3/23/25 at 10:24 AM the Director of Nursing (DON) was interviewed about infection control concerns and stated, I have given several in-services about Enhanced Barrier Precaution (EBP) multiple times. The sign says when to use the Personal Protective Equipment (PPE). On 3/26/25 at 11:44 AM the DON revealed the nursing educator does frequent rounds on the floors and observes staff performing hygiene care and does on the spot teachings. We have 14 residents under Droplet Precautions for either Covid or exposure to Covid. Staff are required to don a gown, mask, gloves, a face shield is optional. The residents on Droplet Precaution doors should be closed. Some residents don't like having the door closed and request to leave it open. It is not recommended to leave the door open but we try to honor residents' rights and if that can't be done we find alternative means and it is care planned. We in-serviced all staff about Covid outbreak, hand hygiene, donning PPE, early signs and symptoms of Covid on 3/14/25. Staff are to monitor residents' catheters to make sure the urine is draining properly and catheter tubing is not kinked, or touching the floor. The Soiled Utility room door should be kept locked to prevent any infection. Record review of a POLICY/PROCEDURE: SUBJECT: Infection Prevention and Control and Surveillance Program DATE: January, 2020 INTENT: It is the policy of the facility to ensure that the Infection Control Program is designed to prevent, identify, report, investigate, and control the spread of infections and communicable disease for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement; provide a safe, sanitary and comfortable environment; and to help prevent the development and transmission of disease and infection, in accordance with State and Federal Regulations, and national guidelines. PROCEDURE: 1. The facility will establish and maintain an infection prevention and control program under which it: a. Prevents, identifies, reports investigate, and controls the spread of infections and communicable disease in the facility; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An additional record review revealed a Policy titled SUBJECT: Standard and Transmission-based Precautions. DATE: (no date) INTENT: It is the policy of the facility to ensure that appropriate infection prevention and control measures are taken to prevent the spread of communicable disease and infections in accordance with State and Federal Regulations, and national guidelines. PROCEDURE: Transmission-based Precautions 1. Transmission-based precautions include airborne, contact, and droplet precautions. Residents requiring airborne precautions will be transferred to a hospital or other health care facility with airborne precaution capability. Residents that require contact and or droplet precautions may remain at this facility. a. Staff are to put on a mask upon room entry and removed upon room exit of resident placed on droplet precautions. 12. a. Staff are to put on gowns and gloves upon room entry and remove gowns and gloves upon exit of resident room. Further record review revealed a policy titled Enhanced Barrier precautions revealed date written: March 2024 POLICY: Enhanced Barrier Precautions (EBP) will be in place for residents as set forth by CMS guidance pertaining to Multidrug-Resistant Organisms (MDRO's) in Memorandum Ref: QSO-24-08-NH March 20, 2024. Residents will be evaluated on admission for the need for EBP.