STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105711	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shoreside Health and Rehabilitation Center	201 NE 112th Street Miami, FL 33161

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. 45019 Based on observation and interview the facility failed to ensure residents' confidential medical records were secure. As evidenced, two medication carts (Cart #1, Cart #2) on Unit C, were left unattended and the screen for the Electronic Medication Administration Records (EMAR) was unlocked, displaying residents' information on the screen. There were 136 residents residing in the facility at the time of survey. The findings included: On 06/04/24 at 09:00 AM during observation on Unit C, Medication cart # 2 was left unattended with the Electronic Medication Administration Records (EMAR) screen unlocked, displaying patient s' information on the screen. The cart was assigned to Licensed Practical Nurse (Staff A). During this observation, the Director of Nursing (DON) was present in the hallway and noticed the open EMAR screen on the cart and placed a sheet of paper over the screen. The DON reported she is not sure if something is wrong with the screen, because it is not shutting down. On 06/04/24 at 09:02 AM (Staff A) approached the medication cart and noticed the unlocked screen, Staff A stated: I am so stressed, it is my first time with the state surveyors. The DON stated to the nurse; you cannot walk away and leave your computer screen open. The nurse (Staff A) acknowledged DON instructions. Staff A stated, I know I am not supposed to leave the computer screen open when I am not with the cart. 48906 On 06/04/24 at 9:11 AM. During medication administration observation was done on nursing unit C with Staff D, Licensed Practical Nurse, (LPN) using medication cart number one. During the medication administration observation Staff D, LPN walked away from the medication cart number one and entered a resident's room, leaving the computer screen open and resident's personal information visible. On 06/04/24 at 9:15 AM Staff D, LPN returned to medication cart number one and stated to surveyor, I made a mistake. I am supposed to close the computer screen whenever I leave the cart. I didn't close the screen because I forgot.

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45019 Based on observation and interview the facility failed to follow the facility's policy regarding pharmacy procedures. As evidenced by during medication administration observation on Unit C, Licensed Practical Nurse (Staff A) administered an incorrect dosage of insulin to Resident #87. There were two residents that receive routine insulin residing on Unit C. The findings included: On 06/04/24 at 9:17 AM during medication administration observation with Licensed Practical Nurse (Staff A). it was observed that Staff A administered 15 units of Lantus (R) (insulin glargine injection) to Resident# 87's left upper abdomen. Resident # 87 had an order for 16 units of Lantus, 100 Units /ML (units per milliliter) subcutaneously two times a day for Diabetes Mellitus. The surveyor requested Staff A check the orders for Resident #87's Lantus, Staff A checked Resident #87's orders and said the order is for 16 units of Lantus and she gave the resident 15 units. In a situation like this I will speak to my supervisor and see what I need to do, in the meantime I will keep an eye on the resident. On 06/04/24 at 09:37 AM, the Director of Nursing (DON) told the surveyor that Staff A told her about the incorrect insulin dose given to Resident #87, the DON reported she instructed the nurse (Staff A) to give the resident the additional 1 unit of Lantus insulin. Review of the medical records for Resident #87 revealed the resident was admitted to the facility on [DATE], readmitted on [DATE]. Clinical diagnoses included but not limited to: Type 2 diabetes mellitus with hyperglycemia. Review of the Physician's Orders Sheet for June 2024 revealed Resident #87 had orders that included but not limited to: Lantus 100 unit/ml-inject 16 unit subcutaneously two times a day for Diabetes Mellitus. Record review of Resident # 87's Quarterly Minimum Data Set (MDS) dated [DATE], Section C for Cognitive Patterns documented Brief Interview for mental Status Score is 10, on a 0-15 scale indicating the resident is moderately impaired cognitively. Review of the facility policy and procedure titled: Administering Medications revision date April 2019 states: Medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation Step 4. Medications are administered in accordance with prescriber orders, including any required timeframe Step 6. Medication errors are documented, reported, and reviewed by the QAPI committee to inform process changes and or the need for additional staff training. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Step 9. The individual administering the medication checks the label to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medications.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45019 Based on observation, interview and record review the facility failed to ensure the medication error rate was not five (5) percent or greater. As evidenced by during medication administration observations an incorrect dose of insulin was given to Resident #87 and Resident #97 did not receive a prescribed injection for Anemia. There were 136 residents residing in the facility at the time of survey. The findings included: Resident #87 On 06/04/24 at 9:17 AM during medication administration observation with Licensed Practical Nurse (Staff A). It was observed that Staff A administered 15 units of Lantus (R) (insulin glargine injection) to Resident# 87's left upper abdomen. Resident # 87 had an order for 16 units of Lantus, 100 Units /ML (units per milliliter) subcutaneously two times a day for Diabetes Mellitus. The surveyor requested Staff A check the orders for Resident #87's Lantus, Staff A checked Resident #87's orders and said the order is for 16 units of Lantus and she gave the resident 15 units. In a situation like this I will speak to my supervisor and see what I need to do, in the meantime I will keep an eye on the resident. On 06/04/24 at 09:37 AM, the Director of Nursing (DON) told the surveyor that Staff A told her about the incorrect insulin dose given to Resident #87, the DON reported she instructed the nurse (Staff A) to give the resident the additional 1 unit of Lantus insulin. Review of the medical records for Resident #87 revealed the resident was admitted to the facility on [DATE], readmitted on [DATE]. Clinical diagnoses included but not limited to: Type 2 diabetes mellitus with hyperglycemia. Review of the Physician's Orders Sheet for June 2024 revealed Resident #87 had orders that included but not limited to: Lantus 100 unit/ml-inject 16 unit subcutaneously two times a day for Diabetes Mellitus. 48906 Resident #97 During an observation on 6/05/24 at 09:19 AM Staff E, Registered Nurse (RN) weighed Resident #97 and transferred the resident to the in-house dialysis center. Staff E, RN was stopped by surveyor and asked who is responsible for administering the RETACRIT(R) injection scheduled to be given that morning to Resident #97. Staff E, RN responded: I am responsible for administering the injection. I was going to administer the injection, but time got away from me. I will speak with the doctor now. Record review of demographic sheet for Resident #97 revealed an admitted [DATE] and re admitted [DATE] with diagnosis that included Anemia. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of physician orders for Resident #97 revealed an order dated 5/15/24 for RETACRIT(R) Injection Solution 4000 UNIT per Milliliter (ml) Inject 4000 ml subcutaneously in the morning, every Monday, Wednesday, and Friday for Anemia, schedule 8:00 AM. Record review of most recent laboratory blood work dated 5/22/24 revealed a hemoglobin level of 8.8 (may indicate anemia). On 6/05/24 at 10:25 AM the Director of Nursing (DON) stated: Every Friday we have a Standard of Care meeting where we discuss dialysis residents and the care needed. This medication should have been given by 9:00 AM. I informed [Resident #97's] primary care physician (PCP) about the medication omission, [Resident #97] was assessed by the PCP while in dialysis, and a new order was received to administer the RETACRIT(R) injection to [Resident #97] at noon today. During a follow up observation, Staff E, RN administered the RETACRIT(R) injection at 12:32 PM while Resident #97 was in dialysis. Review of the facility policy and procedure titled: Administering Medications revision date April 2019 states: Medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation Step 4. Medications are administered in accordance with prescriber orders, including any required timeframe Step 6. Medication errors are documented, reported, and reviewed by the QAPI committee to inform process changes and or the need for additional staff training. Step 9. The individual administering the medication checks the label to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medications.