STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105803	A. Building B. Wing	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Terrace of Hialeah, The	190 W 28th Street Hialeah, FL 33010

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45019 Based on observation, record review and interview, the facility failed to provide a clean and sanitary environment for residents as evidenced by during several observations, garbage was observed on the floor in several residents' rooms, bed linen was observed on resident's bed with multiple holes, hole in wall in resident's room, and dirty walls in resident's room. There were 231 residents residing in the facility at the time of the survey. The findings Included: During observation on 06/23/24 at 06:18 AM rooms [ROOM NUMBERS] were observed with garbage on the floor. On 06/23/24 at 06:35 AM room [ROOM NUMBER] was observed with garbage on the floor, on 06/23/24 at 06:39 AM room [ROOM NUMBER] was observed with garbage/papers on floor, on 06/24/24 at 07:41 AM room [ROOM NUMBER] bed A was observed with several holes on the bed linen. On 6/24/24 at 11:00 AM room [ROOM NUMBER] was observed with a huge hole in the wall close to the electrical outlet and several brown colored stains on the wall (Photos available). Interview on 06/25/24 at 08:24 AM. The Director of Nursing (DON) and Corporate Nurse were shown the photos of environmental concerns, the DON stated the hole in the wall in room [ROOM NUMBER] was fixed yesterday and the wall cleaned, and they will be addressing the housekeeping issues observed with the housekeeping staff. Regarding the torn bed linen observed by the surveyor, they will do an audit, and any linen that is not up to facility standards will be discarded immediately and replaced. Interview on 06/25/24 at 10:58 AM. The Director of Maintenance stated: I have been working here for one month, I noticed the hole in the wall in room [ROOM NUMBER] a few days ago, to fix the whole we put compound in the wall, cut the whole out, let it dry, sand and painted the area. This was completed on 6/24/24. There is a maintenance book in each nursing station, where staff write down any maintenance issues to be addressed. Maintenance staff check all the books for maintenance issues daily in the morning, once the issue is fixed, I personally do an inspection of the area and then the staff that fixes the issue signs off on the issue as completed with the date, time and signature. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105803	A. Building B. Wing	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Terrace of Hialeah, The	190 W 28th Street Hialeah, FL 33010

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/25/24 at 11:04 AM. The Director of Housekeeping stated: I have been working at this facility for 8 years. My housekeeping staff schedule is-day shift 6:30 AM to 2:53 PM, seven (7) housekeepers, 5-1:30PM, three (3) persons for garbage removal, 1-9:30PM, one (1) person for disinfection, spills, cleanup, and garbage removal. The morning housekeeping staff- in the mornings when they come in, they start cleaning the offices and common areas and then move on to the resident's, they try not to be in the residents' room too early in the morning cleaning. Review of the facility's policies and procedures titled Physical Environment revision date 1/04/24 states: Floors shall be maintained in a clean, safe, and sanitary manner. Procedures: 1. All floors shall be mopped/cleaned/vacuumed daily in accordance with our established procedures.

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NAME OF PROVIDER OR SUPPLIER Terrace of Hialeah, The		STREET ADDRESS, CITY, STATE, ZIP CODE 190 W 28th Street Hialeah, FL 33010	

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45019 Based on observation, record review and interview, the facility failed to ensure one (Resident #435) out of 35 sampled residents was free from the use of physical restraints. As evidenced by during an observation the resident's bed was positioned with the foot of the bed elevated and the head of the bed flat, the overbed table was positioned by the side of the bed in the middle, preventing the resident from getting out of the bed without assistance. There were 231 residents residing in the facility at the time of the survey. The findings included: During observation on 06/23/24 at 06:18 AM, Resident #435 was in bed asleep, the bed was in the lowest position, the foot of the bed was elevated, and the head of the bed flat, the overbed table was positioned by the side of the bed in the middle (photo available). Observation on 06/24/24 at 07:45 AM the resident was in bed asleep, the bed was in the lowest position, in flat position from head to toe and the overbed table at the side of bed. On 06/25/24 at 11:30 AM the resident was in bed asleep, the bed was flat and in the lowest position from head to toe with the overbed table at the side of bed, Review of the medical records for Resident #435 revealed the resident was admitted to the facility on [DATE]. Clinical diagnoses included but not limited to: Depression. Review of the Physician's Orders Sheet for June 2024 revealed Resident #435 had orders that included but not limited to: Turn and reposition every 2 hours as needed. Mirtazapine tablet 30 mg (milligrams) give 1 tablet by mouth at bedtime related to depression. Trazodone oral tablet 50 mg -give 1 tablet by mouth two times a day related to depression and Behavior Monitoring for use of Trazodone due to Depression. Record review of Resident #435 's Admission Minimum Data Set (MDS) dated [DATE]; Section C for Cognitive Patterns documented Brief Interview for Mental Status (BIMS) score of 8 on a 0-15 scale, indicating the resident is moderately cognitively impaired. Section GG for Functional Status documented resident is dependent for care. Section E for Mood and behavior documented no behaviors exhibited. Section J for Health Conditions documented no falls since admission, no scheduled or as needed medication administered in the last 5 days and Section P for Alarms and restraints documented no physical restraints or alarms used. Record review of Resident #435 's Care Plans Reference Date 06/07/24 revealed the resident uses antidepressant medication related to depression. Interventions include- Administer antidepressant medications as ordered by physician. Educate the resident/family/caregivers about risks, benefits and the side effects and/or toxic symptoms of medications as indicated. Monitor/document/report as needed adverse reactions to antidepressant therapy; change in behavior/mood/cognition; hallucinations/delusions; social isolation, suicidal thoughts . (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Terrace of Hialeah, The		STREET ADDRESS, CITY, STATE, ZIP CODE: 190 W 28th Street Hialeah, FL 33010	

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/25/24 at 08:09 AM, the Director of Nursing (DON) after seeing the photo of the resident's bed positioning stated: We will do a one-to-one teaching with the whole staff about restraints, educate all the staff about restraints, evaluate the residents for behaviors and investigate the resident's assigned staff on the day of the surveyor's observation to see the reason for the bed being positioned the way it was. Restraints is anything that does not allow the residents to independently move by themselves. On 06/26/24 at 12:59 PM an attempt using the number provided to conduct a telephone interview with the 11:00 PM to 7:00 AM Registered Nurse (Staff E), that was assigned to Resident #435 on 6/23/24 was unsuccessful. A message was left with the assistance of another surveyor on the team to translate from Spanish to English with the surveyor's name and phone number along with the survey information. On 06/26/24 at 01:22 PM. Certified Nursing Assistant (Staff D) from the 11:00 PM to 7:00 AM shift, assigned to Resident #435 on 6/23/24, attempted twice to contact Staff D via telephone with number provided by the facility with another surveyor on the team to help with translation from Spanish to English; a message was left with surveyor name and phone number and the survey information. Review of the facility policy and procedure titled Restraints revision date 10/06/24 states: The purpose is to ensure each resident is to attain and maintain his/her highest practicable wellbeing in an environment that prohibits the use of restraints for discipline or convenience and limits restraint use to circumstances in which the resident has medical symptoms that warrant the use of restraints. To ensure residents are provided a safe environment and the use of restraints is carefully monitored to protect resident rights, personal comfort and safety, assuring the least restrictive means are used.

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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** 42532 Based on observation, interview and record review facility failed to ensure the Preadmission Screening and Resident Review (PASRR) Level I PASRR was not completed for four (Resident # 60, Resident # 3, Resident #112 and Resident #127) out of four residents investigated. This deficiency had the potential to affect 231 residents residing in the facility at the time of the survey. The findings included: Resident # 60 During multiple observations starting on 06/23/24 to 06/26/24, Resident # 60 was in the room in bed and no distress noted. The resident never responded to questions asked. Record review of the clinical records for Resident # 60 revealed the resident was admitted to the facility on [DATE] and readmitted on [DATE]. Clinical diagnoses included, but not limited to, Other Secondary Parkinsonism; Anxiety Disorder, Unspecified; Unspecified Psychosis; Adult Failure to Thrive. Record review of the Admission Minimum Data Set (MDS) Section A Identification dated 05/12/24 revealed the section 1500 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. Record review of PASRR Level I dated 05/12/24 revealed no identification of serious mental diagnosis illness under 1A. Section 1B was not checked for Serious Mental Illness (SMI). Section 2,3 (A/B) and 4 (A/B) were checked No. Section II Part A & B were checked No. Section IV, V and VI were not completed. Record review of Admission MDS Section C Cognitive Patterns dated 05/12/24 revealed the resident Brief Intervention for Mental Status (BIMS) summary score was 03 out of 15. Review of Admission MDS Section I Active Diagnosis the resident's diagnosis were Anxiety and Psychotic Disorder. Review of Annual MDS section N Medications revealed the resident was receiving antipsychotic and antianxiety medication. Review of Psychiatrist Consultation dated 06/24/24. Psychosocial history: Dementia, resident had a lifelong of mental illness characterized as delusion, depression, anxiety mood change. Diagnosis: Bipolar Disorder, Anxiety, Psychosis. continue with the same medications. Interview with Staff F Registered Nurse (RN) on 06/26/24 at 11:43 AM. He revealed Resident # 60 gets agitated if not medicated early so he prioritized her medication due to anxiety and agitations. The resident gets agitated and does not cooperate with the nursing staffing and after medication she gets better. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Social Services Director on 06/26/24 10:47 AM. revealed she has been working in the facility for one month. The protocol for Level I PASRR was as follows: Level I PASRR from the hospital goes to Admissions Department to accept or not to accept the resident. For Resident # 60 the Level I PASRR was not completed, and she did not realize that the form was incomplete. 45019 Resident #3 Observations on 06/23/24 at 06:25 AM, Resident #3 was in bed asleep. On 06/24/24 at 07:50 AM Resident #3 was in bed asleep. On 06/25/24 at 11:27 AM Resident #3 was in bed awake, no distress noted. Record Review of Resident #3's Level I PASRR (Preadmission Screening and Resident Review) documented Section I: PASRR Screen Decision Making: A: Mental Illness (MI) or suspected MI (check all that apply) - no diagnosis checked off. Findings based on documented history were-Section II Other indicators for PASRR screening Decision-Making: All checked-no. Does individual have validating documentation to support dementia or related Neurocognitive disorder - no. Section III Not a provisional admission. Section IV. No diagnosis or suspicion of Serious Mental Illness (SMI) or Intellectual Disability (ID) indicated. Level II PASRR evaluation not required. PASRR Level I completed by a Registered Nurse at the hospital on 08/10/2023. Record Review of Resident #3's most recent Psychological Consultation dated 3/8/24 documented: patient noted with advanced dementia, alert and oriented times one, depression, delusions, insomnia, responding to medications. Review of the medical records for Resident #3 revealed the resident was admitted to the facility on [DATE]. Clinical diagnoses included but were not limited to: 8/10/23-unspecified psychosis not due to a substance or known physiological condition. 8/10/23-depression. 8/10/23-dementia in other diseases classified elsewhere, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety Review of the Physician's Orders Sheet for June 2024 revealed, Resident #3 had orders that included but not limited to: Seroquel oral tablet 25 mg (Quetiapine Fumarate)-give 12.5 mg by mouth in the evening related to unspecified psychosis not due to a substance or known physiological condition. Trazodone tablet 50 mg-give 25 mg by mouth at bedtime related to depression, unspecified - administer at bedtime. Temazepam capsule 15 mg-give 1 capsule by mouth at bedtime related to insomnia. Record review of Resident # 3's Quarterly Minimum Data Set (MDS) dated [DATE] revealed: Section A 1500 resident is currently considered by the state level II PASRR process to have a SMI or ID or a related condition-Not available. Section C for Cognitive Patterns documented Brief interview for mental status score (BIMS), 3 on a 0-15 scale indicating the resident is cognitively impaired. Section I for Active diagnosis documented Psychotic disorder and Depression Disorder. Section N for Medications documented resident is taking antipsychotic, antidepressant, hypnotic, diuretic and antiplatelets medications. Section O for Special Treatments documented resident is on hospice care. (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 Resident #3 's Care Plans Reference Date 05/14/24 revealed: resident is at risk for adverse reactions related to the use psychotropic meds On Anti-anxiety medication (DC), Antidepressant Medication, On Anti-Psychotic Medication, On Sedative-Hypnotic Medication. Interventions include-Will remain free of signs and symptoms of over sedation and side effects related to psychotropic medication. Involve the family and resident with the care planning process and psychotropic reduction program. Monitor behavior for effectiveness of medications. Monitor for signs and symptoms of over-sedation and/or changes in condition. Obtain laboratory tests and/or vital signs as ordered. 48906 Resident #112 Record review of Resident #112's Preadmission Screening and Resident Review (PASRR) dated 5/7/24 Section I: PASRR Screen Decision-Making: Depressive Disorder was checked, Section IV: PASRR Screen Completion: No diagnosis or suspicion of Serious Mental Illness or Intellectual Disability indicated. Level II PASRR evaluation not required, signed on 5/7/24 by social worker of nearby hospital. Record review of demographic sheet for Resident#112 revealed an admitted [DATE] with diagnosis that included Anxiety Disorder and Depressive disorders. Record review of Admission Minimum Data Set (MDS) dated [DATE] for Resident #112, Section A for Identification revealed Preadmission Screening and Resident Review (PASRR) was completed and the resident was not currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. Section I for Active diagnosis revealed a diagnosis of Depression. Section N revealed resident was taking an antidepressant and antipsychotics were received on a routine basis since admission, a gradual dose reduction (GDR) has been attempted, last attempt on 5/16/24, and the physician did not document GDR as clinically contraindicated. Section O for special treatments revealed no psychological therapy in last seven days. Record review of Care Plan date initiated on 5/10/24 and start date 5/16/24 revealed Resident #112 was at risk for adverse reactions related to the use psychotropic meds, on Anti-Depressant Medication, On Anti-Psychotic Medication. Interventions included monitoring behavior for effectiveness of medications and signs and symptoms of over-sedation and or changes in condition. Record review of physician orders revealed orders dated 5/16/24 for Amitriptyline HCl Tablet 100 mg give 1 tablet by mouth at bedtime for depression and 5/10/24 for psychiatry consult as needed, 6/4/24 to monitor for s/s of depression Resident is taking antidepressant medication, 6/17/24 for Ativan oral Tablet 0.5 MG (Lorazepam) *Controlled Drug* Give 0.5 mg by mouth every six hours as needed for anxiety disorder related to anxiety, 6/19/24 for Behavior monitoring for use of Ativan due to: Anxiety, evidenced by periods of calling out, and 6/24/24 for Clonazepam Oral Tablet 0.5 milligrams (MG) *Controlled Drug* Give 0.25 mg by mouth two times a day related to anxiety disorder. Record review of a Psychiatric Consult dated 5/16/24 revealed diagnosis of Depression and Anxiety. (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 Preadmission Screening and Resident Review (PASRR) dated 5/30/24 revealed Section I: PASRR Screen Decision-Making: Anxiety and Depressive disorder checked, Schizoaffective disorder and Bipolar are not checked Section IV: PASRR Screen Completion: No diagnosis or suspicion of Serious Mental Illness or Intellectual Disability indicated. Level II PASRR evaluation not required, signed on 5/30/24 by DON. Resident #127 Record review of demographic sheet for Resident#127 revealed an admitted [DATE] and readmission of 3/17/24 and diagnosis that included anxiety disorder and bipolar disorder. Record review of Discharge Return Anticipated Minimum Data Set (MDS) dated [DATE]-Discharge Return Anticipated, Section I for Active diagnosis revealed diagnosis of anxiety disorder and bipolar disorder. Section N for medications revealed Resident #127 was taking Antianxiety medication in the last 7 days and Section O for special treatment revealed no therapies coded. Record review of Care Plan date initiated 2/2/22 and start date 4/3/24 revealed Resident #127 was at risk for adverse reactions related to the use psychotropic meds on Anti-Anxiety Medication and on Anti-Psychotic medication with interventions that included monitor behavior for effectiveness of medications, monitor for signs and symptoms of over-sedation and or changes in condition. Record review of Psychiatric Note dated 5/23/24 revealed Resident #127 had diagnosis of Schizoaffective disorder, bipolar type and Anxiety. Record review of physician orders revealed orders dated 6/6/24 for Clonazepam Oral Tablet 1 mg *Controlled Drug* Give one by mouth two times a day related to anxiety disorder. On 06/25/24 at 11:50 AM the Social Services Director stated: I started working in this facility 4 weeks ago and I am going thru all the PASRRs to make sure they are correct. There are a lot of outdated PASRRs that I am correcting. I don't have a physical audit form regarding correcting the PASRRs. The nurses are to inform me during the morning meeting whenever a new qualifying diagnosis is obtained for the resident the I complete a PASRR for that resident on 5/23/24. (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 Policies and Procedures for Preadmission Screening and Annual Resident Review (PASARR) Effective date 11/28/2012 last review 10/17/2023. Guidelines: It is the policy to screen all potential admissions on an individualized basis. As part of the preadmission process, the facility participates in the Preadmission Screening and Resident Review (PASRR) screening process (Level I) for all new and readmission per requirement to determine if the individual meets the criterion for mental disorder (SMI/SMD), intellectual disability (ID) or related condition. Based upon the Level I screen, the facility will not admit and individual with a mental disorder or intellectual disability until the Level II screening process has been completed and the recommendations allow for a nursing facility admission and the facility's ability to provide the specialized services determined in the Level II screen. If a provisional admission to the facility is approved via the Level II screen process, the facility will coordinate with the State PASRR representative related to the individual needs of the resident as indicated. Annually and with any significant change of status, the facility will complete the PASRR Level I screen for those individuals identified per the Level II screen requiring specialized services. The facility will report any changes as identified via the screen to the state mental health authority or state intellectual disability authority promptly. Objective PASRR Policy. The objective of the PASRR policy is to ensure that individuals with mental illness and intellectual disabilities receive the care and services that they need in the most appropriate setting. The PASRR will be evaluated annually and upon any significant change for those individuals identified. Procedure: 1-Admissions and Readmissions: a) The facility will participate in or complete the Level I screen for all potential admissions regardless of payer source to determine if the individual meets the criterion for mental disorder (SMI/SMD) intellectual disability (ID) or related condition.

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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 facility failed to provide a safe environment for one resident (Resident #188) out of ten residents sampled as evidenced by a bundle of shaving razors observed in the drawer next to the resident's bed. There were 231 residents residing in the facility at the time of survey. The findings included: On 06/23/24 at 11:27 AM Resident#188 was observed laying in bed with eyes closed, a bundle of shaving razors was observed in the drawer next to bed. (photo evidence) On 06/23/24 at 11:27 AM Staff G, Registered Nurse (RN) was notified by surveyor and entered room with surveyor. Staff G, RN retrieved the bundle of razors and stated; these razors should not be in here for safety reasons because [Resident #188] can reach into drawer. I think a staff member left the razors in drawer. Record review of demographic sheet for Resident #188 revealed an admitted [DATE] with diagnosis that included Alzheimer's disease with late onset. Record review of Annual Minimum Data Set (MDS) dated [DATE], Section C for cognitive patterns revealed a Brief Interview for Mental Status (BIMS) score of 3 out of a scale of 0-15 indicated severe cognitive impairment. Section E for behavior revealed no Potential Indicators of Psychosis. Section GG for functional status revealed R#188 was dependent for Activities of Daily Living (ADL). Record review of Care Plan date initiated 3/27/23 and start date 3/31/24 revealed Resident #188 was at risk for falls related to unawareness of safety needs with interventions that included: maintain an environment free of clutter. On 06/23/24 at 1:28 PM Staff L, Certified Nursing (CNA) (translated by the DON) stated: I have been employed for seven years in this facility; when I start my shift, I check all the residents, tell them what I am going to do and I check all their personal belongings to make sure there are no objects that can be used to harm themselves or others like knife or forks. Razors cannot be kept in resident's rooms, once used the razors need to be placed in the sharps container. On 06/26/24 at 10:03 AM, the DON stated: Residents are not allowed to keep razors in their rooms. staff check residents' drawers every day to ensure that there are no objects that harm anyone. (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 policy for Hazardous Areas, Devices, and Equipment. Revised July 2017. Policy Statement: All hazardous areas, devices, and equipment in the facility will be identified and addressed appropriately to ensure resident safety and mitigate accident hazards to the extent possible. Policy Interpretation and Implementation: 1. As part of the facility's overall safety and accident prevention program, hazardous areas and objects in the resident environment will be identified and addressed by the Safety Committee. Identification of Hazards: 1. A hazard is defined as anything in the environment that has the potential to cause injury or illness. Examples of environmental hazards include, but are no limited to : c. Sharp objects that are accessible to vulnerable residents.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45019 Based on observations, record review and interviews, the facility failed to ensure oxygen therapy was being received as prescribed for one Resident (#123) out of 35 sampled residents. As evidenced by, during several observations of Resident #123 the Continuous Positive Airway Pressure (CPAP) machine was positioned on Resident #123's forehead. The findings included: During several observations on 06/23/24 starting at 06:31 AM, 07:15 AM and 08:03 AM Resident #123 was observed with the CPAP machine located on her forehead. The CPAP machine was turned on and running. 06/24/24 at 07:53 AM Resident #123 was in bed asleep, oxygen (02) was running via nasal cannula (NC) at two (2) liters per minute (LPM), the call light was on the bed. On 06/25/24 at 11:29 AM resident was in bed awake, 02 running at 2 LPM via NC, no distress noted. On 06/23/24 at 08:06 AM Registered Nurse (Staff C) assigned to the resident stated that the resident takes off her CPAP machine herself, but it is time for it to be removed for breakfast, the nurse preceded to check the resident's orders and then removed the CPAP machine. The surveyor asked Staff C how often she checks on the resident to see if the machine is on correctly and did she check the resident's oxygen (02) saturation level knowing that the resident takes the machine off sometimes. Staff C stated, I checked her at the beginning of my shift, and I replaced the machine on the resident, she must have taken it off again, I work here part time and I usually work in different areas every day. Review of the resident's 02 saturation levels on 6/23/24 and 6/24/24 documented an average oxygen saturation level of 96% on 2 LPM oxygen via nasal cannula. Review of the medical records for Resident # 123 revealed the resident was admitted to the facility on [DATE]. Clinical diagnoses included but not limited to: Acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure. Chronic obstructive pulmonary disease with (acute) exacerbation. Acute respiratory failure with Hypercapnia and Acute respiratory failure with hypoxia. Review of the Physician's Orders Sheet for June 2024 revealed Resident #123 had orders that included but not limited to: CPAP machine at bedtime with continuous oxygen at 2 liters per minute when use. every 12 hours related to obstructive sleep apnea. Continuous oxygen at 2 liters per minute continuously two times a day related to chronic obstructive pulmonary disease, unspecified. Record review of Resident # 123's Quarterly Minimum Data Set (MDS) dated [DATE] revealed: Section C for Cognitive Patterns documented Brief Interview for Mental Status Score (BIMS) 3 on a 0-15 scale, indicating resident is cognitively impaired. Section GG for Functional Status documented resident is dependent for care. Section J for health conditions documented no shortness of breath. Section O for Special Procedures and Treatments documented the resident is receiving oxygen therapy and Non-invasive Mechanical Ventilator. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Terrace of Hialeah, The		STREET ADDRESS, CITY, STATE, ZIP CODE 190 W 28th Street Hialeah, FL 33010	

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident # 123's Care Plans Reference Date 05/12/24 revealed: The resident has a potential for alteration in respiratory functioning related to chronic Obstructive Pulmonary Disease (COPD), Obstructive Sleep Apnea, continuous oxygen (02). Interventions include- Administer oxygen as ordered, monitor oxygen saturation as ordered and as needed. Assess respiratory status, observe for shortness of breath, monitor lung sounds. Call physician for any changes in condition and as needed. change oxygen mask, tubing and humidifier as ordered, CPAP machine as ordered, provide treatments as ordered. Remind resident to deep breath and cough.; and wear ear protector for nasal cannula. On 06/25/24 at 08:05 AM, the Director of Nursing (DON), and Corporate Nurse Consultant were shown the photo of the CPAP machine positioned on the resident's forehead. Review of the facility's policy and procedure titled Oxygen Concentrator revision date 05/04/23 states: The purpose of this policy is to establish responsibilities for the care and use of oxygen concentrators. Policy Explanation and Compliance Guidelines: 2. Oxygen is administered under orders of the attending physician, except in case of an emergency.

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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, interview and record review the facility failed to ensure pharmaceutical procedures were followed during medication administration observation for two residents (Resident # 12 and Resident #201) out of six (6) residents sampled) as evidenced by the omission of two (2) medications for residents during medication administration observations with Registered Nurses. In addition, the facility failed to ensure the narcotic count was correct for two residents (Resident #145 and Resident #73). There were 231 residents residing at the facility at the time of the survey. The findings included: During medication administration observation on 6/23/24 at 8:21 AM with Registered Nurse (Staff A), the prescribed medication-Simethicone 125 milligram (mg) 1 capsule daily was not available on the medication cart in the capsule form as prescribed to be given to Resident #12. Staff A called central supply in the facility and the staff in central supply reported the medication was not available in capsule form, only tablets. Simethicone 125 milligram (mg) 1 capsule daily was not given during the medication administration observation with the surveyor. Review of medical records for Resident #12 revealed the resident was admitted to the facility on [DATE]. Clinical diagnoses included but not limited to: Encounter for surgical aftercare following surgery on the digestive system. Record Review of the Physician's Orders Sheet for June revealed Resident #12 had orders that included but not limited to: Simethicone Oral Capsule 125 mg (Simethicone)-Give 1 capsule by mouth every 6 hours related to encounter for surgical aftercare following surgery on the digestive system. Record review of Resident # 12's Annual Minimum Data Set (MDS) dated [DATE] revealed: Section C for Cognitive Patterns documented a Brief Interview for Mental Status (BIMS) score of 9 on a 0-15 scale, indicating the resident is moderately impaired cognitively During an interview Registered Nurse, Staff A, stated: I called central supply and they do not have the medication available in capsule form, I will call the resident's doctor (MD) for new orders and notify the surveyor on what the new orders will be. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During medication administration observation on 6/23/24 at 9:00 AM with Registered Nurse (Staff B), the prescribed medication- Amlodipine Besylate oral tablet 10 mg- Give 10 mg orally one time a day was not given to Resident #201 during the medication administration observation. Before entering Resident #201's room to administer the medications, the surveyor asked Staff B how many pills he had in the medication cup, Staff B-stated he had five (5) medications in the medication cup, Staff B entered the resident's room, gave the medications to the resident, exited the room, and documented all the resident's medications as given in the electronic medication administration record (EMAR). The surveyor asked Staff B to check/count how many medications the resident was supposed to receive, Staff B, checked the resident's prescribed ordered medications and realized that he had not given the Amlodipine 10 mg as prescribed to Resident #201, Staff B asked the surveyor if he could give the resident the missing medication, the surveyor referred Staff B to the facility policy, Staff B stated that he is allowed to give the missing medication to the resident and proceeded to give the medication-(Amlodipine 10 mg) to, Resident #201. Review of medical records for Resident #201 revealed the resident was admitted to the facility on [DATE]. Clinical diagnoses included but not limited to: Hypertensive heart disease with heart failure Review of the Physician's Orders Sheet for June revealed Resident #201 had orders that included but not limited to: Amlodipine Besylate oral tablet give 10 mg orally one time a day related to hypertensive heart disease with heart failure hold if systolic blood pressure is less than 110 mm hg (millimetre of mercury) or diastolic blood pressure less than 60 mm hg or pulse less than 60 beats per minute. Review of Resident # 201's Significant Change Minimum Data Set (MDS) dated [DATE] revealed: Section C for Cognitive Patterns documented Brief Interview for Mental Status (BIMS) score 13 on a 0-15 scale, indicating resident is cognitively intact. On 6/23/24 at 9:20 AM Registered Nurse, Staff B stated he is still allowed to give the resident the medication even though it was missed on the initial medication pass. On 06/25/24 at 08:20 AM, the Director of Nursing (DON) stated: I am aware of the issues identified during medication administration observation, we have already started education with the nurses, the residents' orders were reviewed, and the necessary changes were made. Review of the facility policy and procedures titled Medication Administration revision date 2/20/24 states: Medications are administered by license nurses, or other staff who are legally authorized to do so in the state, as ordered by the physician, and in accordance with professional standards of practice, in a manner to prevent contamination or infection. 48906 On 06/24/24 at 3:45 PM a controlled medication count was completed with Staff J, Registered Nurse (RN) in Nursing Unit Center Court on medication cart one, the Narcotic Drug Count Record sign in /out sheet for Unit C. Court Cart one Month/Year June 2024 no signature for 7:00 AM to 3:00 PM off going staff. (see photo evidence). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review revealed the Medication Monitoring/ Control Record for Resident #145 Clonazepam 0.5 mg one tablet by mouth twice daily noted the last signature was Staff J, Registered Nurse (RN) on 6/23/24 at 4:18 PM, noted number of medications remained as 55. However, on the Bingo card for Resident #145 the Clonazepam 0.5 mg one tablet by mouth twice daily contained 54 tablets and the Medication Administration Record for 6/24/24 for Resident #145 revealed Clonazepam 0.5 mg was given at 9:01 AM by Staff G, RN. (see photo evidence). Further review revealed the Medication Monitoring/ Control Record for Resident #73's Tramadol 50 mg (Ultram) take 1 tablet (50 mg) by mouth twice daily for nonacute pain was last signed by Staff J, RN on 6/23/24 at 4:30 PM, bingo card contains 21 tablets, and the Medication Administration Record for June 2024 for Resident #73 Tramadol 50 mg was given at 8:32 AM by Staff G, RN. (see photo evidence). On 06/24/24 at 3:59 PM Staff J, RN stated: when I start my shift, I reconcile the controlled medications by counting with the previous nurse, then we both sign the sign in sheet to indicate the count is correct. Today I counted with the previous nurse, but that nurse did not sign out the medications he administered. Once I dispense any controlled medication pill into the medication cup I sign after resident takes it. On 06/26/24 at 10:03 AM, the DON stated, nurses should sign out the controlled medication at the time they remove the pill from the bingo card and when leaving the shift, they must count with off going and oncoming nurse to verify the correct count. On 06/26/24 at 12:49 PM Staff G, RN stated he counts controlled medications with the off going nurse and on coming nurse; and I sign in or out on the sign in to verify that we count is correct. I missed these two medications due to the paper being stuck together. I always sign once I administer any controlled medication. This was a mistake. Record review of the facility's Policy: Narcotic/ Controlled Substances- Counting. Effective Date: 11/28/12. Review/Revisions: 11/26/17, 12-/20/21, 11/6/21, 10/30/23. Purpose: 1. To count controlled substances with a partner and to verify the accuracy of the log sheets. General Guidelines: 1. Always participate in the counting of the controlled substances at the beginning and end of your shift. Never say, go ahead without me and I'll sign later. Never leave it to someone else's discretion when you are the one on duty. If you do not observe the medications that you sign as being present, you may be implicated if the medications are later missing. general Procedure for Counting Controlled Substances: 1. Follow your facilities specific guidelines and use their specific log sheet.

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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 the omission of two (2) medications for residents during medication administration observations with Registered Nurses. There were 231 residents residing at the facility at the time of the survey. The findings included. During medication administration observation on 6/23/24 at 8:21 AM with Registered Nurse (Staff A), the prescribed medication-Simethicone 125 milligram (mg) 1 capsule daily was not available on the medication cart in the capsule form as prescribed to be given to Resident #12. Staff A called central supply in the facility and the staff in central supply reported the medication was not available in capsule form, only tablets. Simethicone 125 milligram (mg) 1 capsule daily was not given during the medication administration observation. Registered Nurse, Staff A, stated the resident's doctor (MD) will be called for new orders and notify the surveyor on what the new orders will be. Review of medical records for Resident #12 revealed the resident was admitted to the facility on [DATE]. Clinical diagnoses included but not limited to: Encounter for surgical aftercare following surgery on the digestive system. Record Review of the Physician's Orders Sheet for June revealed Resident #12 had orders that included but not limited to: Simethicone Oral Capsule 125 mg (Simethicone)-Give 1 capsule by mouth every 6 hours related to encounter for surgical aftercare following surgery on the digestive system. Record review of Resident # 12's Annual Minimum Data Set (MDS) dated [DATE] revealed: Section C for Cognitive Patterns documented a Brief Interview for Mental Status (BIMS) score of 9 on a 0-15 scale, indicating the resident is moderately impaired cognitively During medication administration observation on 6/23/24 at 9:00 AM with Registered Nurse (Staff B), the prescribed medication- Amlodipine Besylate oral tablet 10 mg- Give 10 mg orally one time a day was not given to Resident #201 during the medication administration observation. Before entering Resident #201's room to administer the medications, the surveyor asked Staff B how many pills he had in the medication cup, Staff B-stated he had five (5) medications in the medication cup, Staff B entered the resident's room, gave the medications to the resident, exited the room, and documented all the resident's medications as given in the electronic medication administration record (EMAR). The surveyor asked Staff B to check/count how many medications the resident was supposed to receive, Staff B, checked the resident's prescribed ordered medications and realized that he had not given the Amlodipine 10 mg as prescribed to Resident #201, Staff B asked the surveyor if he could give the resident the missing medication, the surveyor referred Staff B to the facility policy, Staff B stated that he is allowed to give the missing medication to the resident and proceeded to give the medication-(Amlodipine 10 mg) to, Resident #201. Review of medical records for Resident #201 revealed the resident was admitted to the facility on [DATE]. Clinical diagnoses included but not limited to: Hypertensive heart disease with heart failure (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 the Physician's Orders Sheet for June revealed Resident #201 had orders that included but not limited to: Amlodipine Besylate oral tablet give 10 mg orally one time a day related to hypertensive heart disease with heart failure hold if systolic blood pressure is less than 110 mm hg (millimeter of mercury) or diastolic blood pressure less than 60 mm hg or pulse less than 60 beats per minute. Review of Resident # 201's Significant Change Minimum Data Set (MDS) dated [DATE] revealed: Section C for Cognitive Patterns documented Brief Interview for Mental Status (BIMS) score 13 on a 0-15 scale, indicating resident is cognitively intact. On 6/23/24 at 9:20 AM Registered Nurse, Staff B stated he is still allowed to give the resident the medication even though it was missed on the initial medication pass. On 06/25/24 at 08:20 AM, the Director of Nursing (DON) stated: I am aware of the issues identified during medication administration observation, we have already started education with the nurses, the residents' orders were reviewed, and the necessary changes were made. Review of the facility policy and procedures titled Medication Administration revision date 2/20/24 states: Medications are administered by license nurses, or other staff who are legally authorized to do so in the state, as ordered by the physician, and in accordance with professional standards of practice, in a manner to prevent contamination or infection.

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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. 48906 Based on observations, interviews and record review facility failed to properly store medications for two residents (Resident #73, Resident #24) out of ten residents sampled as evidenced by observations of a bottle of vitamins on the side table next to Resident#73 and a nasal spray and rubbing alcohol on Resident #24's side table. There were 231 residents residing in the facility at the time of survey. The findings included: On 06/23/24 at 11:21 AM Resident #73 was observed in bed awake and alert. A bottle labeled {supplement} was observed on the resident's side table next to the bed. (photo evidence) On 06/23/24 at 11:22 AM Staff G, Registered Nurse (RN) was notified by surveyor and entered the room with the surveyor. Staff G, RN removed the bottle labeled [supplement] and explained to the resident that she is not allowed to keep any medications at bedside without first notifying the nurse. Resident #73 replied ok. On 06/23/24 at 11:22 AM Staff G, RN stated: I do rounds when I start my shift and check each resident. I did not observe this medication at the resident's bedside. I will notify the physician. On 06/23/24 at 11:17 AM Resident #24 was observed walking into room. A bottle labeled [Brand} Nasal Decongestant was observed on overbed table and a bottle labeled [Brand} rubbing alcohol on the side table next to the bed (photo evidence). On 06/23/24 at 11:18 AM Staff H, RN was notified by surveyor and entered the room with the surveyor. Staff H, RN removed the bottle and explained to Resident #24 that medications are not allowed to be kept at bedside without first notifying the nurse. Resident #24 responded ok. On 06/23/24 at 11:20 AM Staff H, RN stated: I did not see this medication upon initial rounds, and I will notify the physician. On 06/26/24 at 10:03 AM The director of Nursing (DON) stated: Residents are not allowed to keep medications in rooms without an order from the doctor and assessed by the nursing. Record review of Policy: Medication Storage effective date: 10/1/15 Revisions: 2/5/18, 7/2/19, 5/5/22, 10-11-23. Purpose: To ensure proper storage, labeling and expiration dates of medications, biologicals, syringes and needles. Guidelines: 2. Facility should ensure that medications and biologicals are stored in an orderly manner in cabinets, drawers, carts, refrigerators/freezers of sufficient size to prevent crowding.

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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. 45019 Based on observations, interview and record review, the facility's quality assurance and assessment committee failed to demonstrate effective plan of actions were implemented to correct identified quality deficiencies in problem areas related to repeated deficient practices for F645 PASRR Screening for Mental Diagnosis (MD) and Intellectual Disability (ID), F755 Pharmacy Services and Procedures and F689 Free of Accidents and Hazards. The facility was cited for F645, F689 and F755 in 2023. These repeated deficient practices have the potential to affect any of the 231 residents residing in the facility at the time of the survey. The findings included: Record review of the facility policy and procedure title Quality Assurance Performance Improvement (QAPI) Program, implemented November 2012, revised November 2023 indicate: The purpose of the QAPI program is to ensure the organization has an organized quality assessment and improvement process program that includes performance measurement, performance assessment and performance improvement and addresses the care and unique services provided by the facility. Guidelines and Standards In accordance with the direction of the board of directors, the Quality assurance Committee will establish a planned, systemic organization wide approach to design processes, measurements, assessments, and improve, organization performance and assure that: Activities are collaborative and the interdisciplinary team, including input from direct care staff, other staff, residents and residents' representatives. Data is systematically collected. Appropriate statistical technique is maintained. Data about its processes or outcomes is maintained. Staff are provided with education concerning the approaches and methods of quality improvement, and are trained in reporting, assessing and improving processes that contribute to improving resident outcomes. Expectations for the committee I terms of functions, reporting methods and appropriateness of systems used to facilitate the collection, management, and analysis of date needed for quality improvement are established. Specific quality assurance measures will be identified to be measured on a continuing basis Committee procedures include analyzing and evaluating the effectiveness of the committee's contribution to improving quality (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Committee ensures collected of data on important process or outcomes related to resident care and organization functions. Adequate resources for assessing and improving the organization's governance, managerial, clinical and support processes are allocated. This includes assignment of personnel and adequate time to participate. In addition, information system and data management processes are provided to support ongoing performance improvement activities. Review of the Quality Assurance and Performance Improvement (QAPI) Committee Meeting Sign-in Sheets dated 03/29/24, 04/29/24, and 05/29/24 documented the facility had a QAA Committee meeting monthly. Attendees included: Administrator, Medical Director, Director of Nursing (DON), Assistant Director of Nursing (ADON), Infection Control Preventionist/Risk Manager, Dietary Manager, Clinical Dietician, Director of Housekeeping, Director of Maintenance, Director of therapy, Director of Human resources, Director of admissions, director of Business office, Director of Social Services, Director of Activities, MDS (Minimum Data Set) Coordinator, and Consultant Pharmacist. During an interview with the Director of Nursing/Quality Assurance (QA), Administrator/QA on 06/27/2024 at 3:24 PM. The Don revealed: The QAA Committee meets every month on the last Friday of the month. The committee consists of the Medical Director, Administrator, DON, Assistant Director of Nursing (ADON) and all interdisciplinary team members. The focus of QA committee is to identify problem issues in the facility, track and trend and identify any opportunities for correction in the systems, implement interventions to correct the issue and monitor the effectiveness of the interventions though audits, staff feedback, town hall meetings with staff, education and training and observations on return demonstrations of trainings.