STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105903	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Azure Shores Rehab	800 NW 95th Street Miami, FL 33150

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 01948 Based on observation, interview, and record review, it was determined that the facility failed to provide housekeeping and maintenance service to maintain a sanitary, safe, orderly, and comfortable interior for the first and second (2/2/) residential living floors. The findings included: During the resident screenings performed by the surveyors on 09/23-24/25, and environment tours conducted on 09/25-26/24 accompanied with the facility's Administrator, Infection Control Preventionist, Corporate Housekeeping Director. and Corporate Registered Nurse, the following were noted: The findings included: FIRST FLOOR: room [ROOM NUMBER] - Room windows screens (2) heavily torn and in disrepair. room [ROOM NUMBER]: Exterior of room chair was stained, worn, and torn. room [ROOM NUMBER] - Fall mat (A-bed) soiled and stained, exterior of over-bed table damaged and in disrepair, bathroom floor soiled and large black stains, and exterior of night-stand (B-bed) damaged and in disrepair. room [ROOM NUMBER] - Exteriors of over-bed table worn and in disrepair, 1 of 2-bathroom light bulbs not working, and exterior of bathroom entry door was worn and in disrepair. room [ROOM NUMBER] - Phone not working properly (A-bed- resident complaining of not receiving calls), wall air-conditioning unit requires re-caulking to the room walls, window screens torn and in disrepair, 1 of 3-bathroom lights not operating, toilet requires recaulking to the floor, and room walls damaged and in disrepair, exterior of over-bed table was damaged and in disrepair. room [ROOM NUMBER] - Room walls damaged and in disrepair, exterior of room charge worn and danged, exterior of over-bed table damaged and in disrepair, and large open area behind room wall mounted air-conditioning unit. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	First Floor Community Shower: Two exterior covers of the ceiling light fixtures were cracked/broken, wheelchair scale was heavily soiled, Shower Stall #2 noted that a ceiling tile was covered in black mold type matter, and floor tile grout located in shower stall #1 and #2 was heavily stained. SECOND FLOOR: room [ROOM NUMBER] - Bathroom floor soiled and numerous large black stains, bathroom light bulb not working, wall area behind wall air-conditioning unit damaged and in disrepair, exterior of room chair worn and in disrepair, over-bed light cord too short for resident use (B-bed). room [ROOM NUMBER] - Bathroom floor soiled and large black stains, bathroom light bulbs not working, room window screens torn and damaged, and exterior of over-bed table (B-ed) damaged and in disrepair. room [ROOM NUMBER] - Room walls damaged and in disrepair, bathroom floor soiled and large black stains, and exterior of room chair was worn and in disrepair. room [ROOM NUMBER] - Exterior of bathroom entry door damaged and in disrepair, bathroom floor soiled and large black stains, exterior of room chair heavily worn and in disrepair, room walls damaged and in disrepair, privacy curtain soiled and stained, exterior of over-bed table damaged and in disrepair, bathroom base boards missing, exterior of night-stand damaged and in disrepair, and landing mat soiled and stained. room [ROOM NUMBER] - Bathroom call light cord wrapped around wall handrail, bathroom floor soiled and large black stains, exteriors over-bed tables damaged and in disrepair, and exterior of room chair worn and damaged. room [ROOM NUMBER] - Room floor soiled, damaged, and stained, bathroom light bulbs not working, and bathroom floor soiled and large black stains. room [ROOM NUMBER] - Exterior of room chair worn and in disrepair, room walls danged and in disrepair, over-bed pull cord (B-bed) too short for resident use, bathroom floor soiled and large black stains. room [ROOM NUMBER] - Exterior of room chair heavily worn and in disrepair, bathroom floor soiled and large black stains, room window screens torn and in disrepair, and overbed light cord (B-bed) too short for resident use. room [ROOM NUMBER] - Room walls damaged and in disrepair, toilet requires re-caulking to the bathroom floor, bathroom floor soiled and large black stains, bathroom call light cord wrapped around wall handrail, and two of three-bathroom light bulbs not working. room [ROOM NUMBER] - Nursing medication ointment packet (opened) left on bathroom sink, bathroom floor soiled and large black stains, interior of toilet bowl heavily soiled, exterior of overbed tables (2) damaged and in disrepair, exterior of room furniture (2) in disrepair, and room walls damaged and in disrepair. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room [ROOM NUMBER] - Exterior of bathroom entry door damaged and in disrepair, room furniture damaged (2) and in disrepair, window screens torn and in disrepair, room walls damaged and in disrepair, and exterior of room chair heavily worn and in disrepair. room [ROOM NUMBER] - Room entry door damaged and in disrepair, exterior of bathroom entry door damaged and in disrepair, bathroom floor soiled and large black stains, room walls damaged and in disrepair, and exterior of room chair heavily worn and in disrepair. room [ROOM NUMBER] - Window screen torn and in disrepair. room [ROOM NUMBER] - Air-conditioning filter heavily soiled and not cleaned on a regular basis room [ROOM NUMBER]- Exterior of room chair heavily worn and in disrepair. room [ROOM NUMBER]- Wardrobe closet missing 1 of 3 drawers. room [ROOM NUMBER] - Air-conditioning filter heavily soiled and not being cleaned on a regular basis. room [ROOM NUMBER] - Room window shades damaged and in disrepair, bathroom floor soiled and large black stains, and room walls damaged and in disrepair. room [ROOM NUMBER] - Bathroom floor soiled and large black stains, toilet requires re-caulking to the bathroom floor, and exterior of room furniture (1) damaged and in disrepair. room [ROOM NUMBER] - Bathroom floor soiled and large black stains, exterior of room chair heavily worn and in disrepair, bathroom base boards missing from wall, and exterior of overbed table (1) in disrepair and damaged. Room # 606 - Exterior of bathroom entry door damaged and in disrepair, room walls damaged and in disrepair, exterior of room chair heavily worn and in disrepair, and bathroom floor soiled and large black stains. room [ROOM NUMBER] - Exterior of bathroom door damaged and in disrepair, bathroom floor soiled and large black stains, bathroom nurse call light wrapped around wall handrail, large hole in room wall, room [ROOM NUMBER] - Wall area around the wall air-conditioning unit was damaged and in disrepair. room [ROOM NUMBER] - Room window blinds broken and in disrepair, and exterior of bathroom door damaged and in disrepair, room [ROOM NUMBER] - Wall area around the wall air-conditioning unit was damaged and in disrepair. Hallway (600 Rooms) - Large area of wall paper torn and missing, and ceiling lights in disrepair. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Hallway (600 Unit) - The walls on the entire hallways were noted to have large areas of peeling and missing wallpaper, and ceiling mounted lights (4) were not properly attached and were in disrepair. Following the 09/25-26/24 tours the findings were again reviewed and confirmed with the facility's Administrator. Further discussion noted that the facility has a computerized computer system for staff to document housekeeping/maintenance issues and concerns. Further stated that it is unknown if the computer system is operational and/or staff is not utilizing the system.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 41837 Based on observations, interview and record review the facility failed to assure services being provided to residents meet professional standards of quality for 1 of 4 of residents observed during med pass (Resident #54). The findings included: Review of the facility's employee handbook with revised date of 2024 under section titled, Personal Appearance, Dress Code and Uniform Policy included the following in part: Nails must be clean, neat and trimmed to 1/4 inch for resident/patient care responsibilities; acrylic and gel nails or any other artificial nails are prohibited under any circumstances. Review of the CDC's (Center for Disease Control) website titled, Clean Hands at https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html Under the section Maintain fingernail and jewelry safety included in part the following: Natural nails should not extend past the fingertip. Do not wear artificial fingernails or extensions when having direct contact with high-risk patients like those at intensive-care units or operating rooms. Germs can live under artificial fingernails both before and after using an alcohol-based hand sanitizer and handwashing. On 09/23/24 at 9:45 AM, observation of med pass with Staff D Licensed Practical Nurse (LPN) for Resident #54; a total of 4 oral medication and 1 inhaler (Breo Ellipta) were administered. Staff D, LPN had long pointed artificial nails with rhinestones on top. The fingernails extended about 1 inch past the edge of her fingers. During an interview conducted on 09/23/24 at 10:00 AM with Staff D, LPN was asked if the facility has a policy about staff fingernails, she stated: I don't think so. During an interview conducted on 9/24/24 at 2:20 PM with Staff J Licensed Practical Nurse/Unit Manager was asked about fingernails for staff, she stated : you cannot have fake fingernails, if they are gel, they have to be short and can only be just past the tip of the fingers like mine. She then showed the surveyor her fingernails and said: mine are gel. During an interview conducted on 09/25/24 at 11:10 AM, Staff C Registered Nurse was asked about fingernails for staff, she revealed they need to be short and not fake. When asked about her fingernails that extended about 1/2 inch past the tip of the fingers, she stated: I didn't know the State was coming.

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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** 41837 Based on record review observations and interviews the facility failed to ensure resident with indwelling urinary catheter receives care to prevent to prevent infection and to provide nephrology consult appointment for 1 of 1 resident observed for catheter care (Resident #117). The findings included: Record review for Resident #117 revealed the resident was admitted to the facility on [DATE] with diagnoses that included the following in part: Sepsis Unspecified Organism, Chronic Kidney Disease Stage 3, Chronic Prostatitis, Retention of Urine Unspecified, Personal History of Urinary (Tract) Infections, and Obstructive and Reflux Uropathy Unspecified. Review of the Minimum Data Set for Resident #117 dated 09/08/24 documented in Section C a Brief Interview of Mental Status score of 15 indicating a cognitive response. Review of the Physician's Orders for Resident #117 revealed an order dated 08/19/24 for Urinary Catheter: Provide catheter care every shift and as needed. On 08/23/24 a physician's order was written for a nephrology consult. 39026 On 09/25/24 at 9:00 AM, the Director of Nursing (DON) was asked where the notes were located for review related to a nephrology consult for the resident. The DON stated he thought the resident had seen a Nephrologist and will provide surveyor a copy of the visit note. On 09/25/24 at 11:50 AM an observation was made of indwelling urinary catheter care provided for Resident #117 by Staff A, Certified Nursing Assistant (CNA). The CNA gathered supplies applied gown, and mask, washed hands, applied gloves, proceeded to prepare resident for catheter care, pulled privacy curtain with gloved hand, removed gloves, did not perform hand hygiene, applied gloves, opened brief, removed gloves, did not perform hand hygiene, applied gloves, adjusted covers, had resident check water temperature, removed gloves, did not perform hand hygiene, applied gloves, held catheter at base of penis and proceeded to wipe catheter from tip of penis down tubing toward drainage bag, she repeated this process 3 times, she removed her gloves, did not perform hand hygiene, put on gloves, had resident roll from side to side to remove the pad from under resident, and secure brief on resident, she removed her gloves, did not perform hand hygiene, put on gloves and pulled blankets over resident. It was noted the catheter tubing was secured to resident's leg, but the tubing was under the resident's left leg During an interview conducted on 09/25/24 at 12:10 PM with Staff A, CNA who stated she has worked at the facility for [AGE] years. When asked about hand hygiene between gloves being removed and put on, she said Oh she should have used hand sanitizer, she forgot, she was nervous. When asked about the catheter tubing placement under Resident #117's left leg, she said; let me fix that right now. She then pulled back the resident's blanket and adjusted the catheter tubing, so it was on top of the resident's leg, not under it. The resident said to her: That is so much more comfortable. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled, Nursing - Catheter Care- Urinary with a revision date of 02/21/23 included in part the following: Maintaining Unobstructed Urine Flow: 1 Check the resident frequently to be sure he or she is not lying on the catheter and to keep the catheter and tubing free of kinks. Infection Control 1 Use standard precautions when handling or manipulating the drainage system. 2 Maintain clean technique when handling or manipulating the catheter, tubing, or drainage bag. Review of the facility's policy titled, Hand Hygiene with a revised date of 02/05/23 included the following in part: 1. All staff should perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice. 2. Reference the table below for conditions and indications where hand hygiene is required. Before applying and after removing personal protective equipment (PPE), including gloves. Use either soap and water or alcohol based hand rub 60% or higher (ABHR is preferred) On 09/25/24 at 2:25 PM an interview was conducted with Staff J, a Licensed Practical Nurse (LPN) unit manager. She was asked if the resident had been seen by a nephrologist. She stated she received a call from the Nephrologist this morning asking about Resident #117. She discussed with the Physician that an appointment had not been made for the resident for a nephrology consult. Staff J stated she thought the reason for the appointment, was due to a high potassium level on 08/23/24 for Resident #117 since the order was written that day. The resident had no appointment scheduled so Social Service scheduled the appointment. Staff J stated if the resident has no appointment scheduled she will ask Social Service to make the appointment so she can schedule transportation also. An interview was conducted with the Social Service Director (SSD) on 09/25/24 at 2:34 PM; the SSD reported she made the appointment today and this is the first time she had been asked to make this appointment. The resident did not have any other nephrology appointment scheduled.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38893 Based on observations, interviews and record reviews, the facility failed to monitor food and supplement intake for 1 (Resident #69) of 7 residents reviewed for nutrition and failed to ensure accurate weights for new admission for 1 (Resident # 323) of 7 residents reviewed for nutrition. The findings included: 1). Resident #69 was admitted to the facility on [DATE]. According to the resident's most recent complete assessment, a quarterly Minimum Data Set (MDS), dated [DATE], resident #69 had a Brief Interview for Mental Status (BIMS) score of 11, indicating that the resident was moderately cognitively impaired. Resident #69's diagnoses at the time of the assessment included: Diabetes Mellitus, Dysphagia and Vitamin deficiency. Resident #69's orders included: Regular diet, Dysphagia Mechanical Soft texture, Regular/Thin Liquids consistency - Fortified food at all meals - 04/11/24 with a revision date of 08/30/24 Health Shake put Amt (Amount) ordered PO (by mouth) - three times a day for supplement 4 oz (ounces) at 10:00 AM, 2:00 PM and HS (bedtime), record amount consumed - 06/25/24 Cyproheptadine HCl Tablet 4 milligrams - Give 1 tablet by mouth in the morning for appetite stimulant - 07/30/24 Resident #69's care plan for nutrition, initiated 04/09/24 with a revision date of 09/22/24, included but not limited to: Resident #69 has a potential nutritional problem related to Past Medical History of type 2 diabetes, dysphagia discontinued feeding tube, receives pleasure feeds, significant weight loss (resident ok with weight change.) readmitted ,d+[DATE] without feeding tube, vitamin deficiency . The goal of the care plan was documented as, Maintain adequate nutrition and hydration by consuming >/=50% of all meals and fluids. Maintain skin integrity. No s/sx (sign /symptoms) of dehydration or malnutrition. Initiated on 07/22/22 with a revision date of 05/14/24 and a target date of 10/10/24. Interventions in the care plan included: Monitor/record/report to MD (Medical Doctor) PRN (as needed) s/sx of malnutrition: Emaciation (Cachexia), muscle wasting, significant weight loss: >5% in 1 month, >7.5% in 3 months, >10% in 6 months. Provide and serve diet as ordered. Provide and serve supplements as ordered. On 06/24/2024, the resident weighed 135 lbs. On 09/19/2024, the resident weighed 124 pounds which is a -8. 15 % Loss. On 03/15/2024, the resident weighed 151 lbs. On 09/19/2024, the resident weighed 124 pounds which is a -17.88% Loss. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #69's electronic health record revealed the staff documented in the last 30 days: Consumption of only one of three meals 6 times during the 30-day look back period. Consumption of only two of three meals 3 times during the 30-day look back period. Did not document consumption of meals 3 times during the 30-day look back period. Consumption of only one of three supplements that were provided 11 times during the 30-day look back period. Consumption of only two of three supplements that were provided 15 times during the 30-day look back period. Did not document consumption of supplements that were provided 4 times during the 30-day look back period. During an interview, on 09/25/24 at 12:26 PM, with the Registered Dietitian (RD), when asked about Resident #69's weight loss, the RD replied, I followed up with the physician and we are going to monitor what she eats, she was on a peg (Percutaneous endoscopic gastrostomy/feeding tube) and when she went to the hospital, they took it out (03/28/24) and she returned on 04/09/24. She consumes 25-75% of meals, typically around 50-75% based on just the food on the plate. I see the tray as she is eating it. We are looking into having a PEG placed. Health Shake comes from the kitchen. I speak to the nurses, and they tell me that she consumes the shakes. At the conclusion of the interview, the RD acknowledged that the documentation was not complete. During an interview, on 09/25/24 at 1:11 PM with Staff J, LPN/UM The Plan Of Care (POC) is where they document. the only time that they document a progress is when they are not eating. On 09/25/24 at 1:15 PM, Staff K, Certified Nursing Assistant) CNA, demonstrated that staff would document in the Plan of care (POC) section in the resident's electronic health record and the documentation would be reflected in the resident's task worksheets. 01948 2) During the resident screening and record review on 09/24/24, it was noted that Resident #323 had a documented admission weight of 190 pounds on 09/18/24, and height of 72 inches. Observation of the resident on 09/24/24 noted the resident to be approximately 72 inches, however the resident appeared underweight/malnourished and could not be 190 pounds The resident appeared to be alert and oriented during the brief observation. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of Resident #323 during the breakfast meal conducted on 09/25/24 at 8:30 AM. Further observation noted the resident could eat independently with tray set-up and was interviewable. Further observation noted the resident was served a Regular/No Added Salt; also noted the resident had a large plastic right leg device. The resident was noted to state that the facility food is terrible; however, the resident had cleaned the entree plate and consumed 100 % of the meal. The resident stated to the surveyor that he was still hungry and had been hungry and not receiving sufficient amount of food on a daily basis. The resident further stated that he was admitted for therapy, a leg/foot wound, and would be discharged home following completion of therapy. During the interview the surveyor asked the resident about his weight and the resident stated he feels he is approximately 170 pounds and at no time was his body weight 190 pounds. During an interview conducted with the facility's Registered Dietitian (RD) on 09/25/24 it was discussed and confirmed that the initial weight of 190 pounds on 0918/24 was incorrect and that the resident is at nutritional risk at the present time. The surveyor requested the RD for a re-weigh and a updated nutritional assessment for Resident #323. On 09/25/24, Resident #323 was re-weighed by facility's nursing staff in the presence of the surveyor and the facility RD. The weight recorded was 164 pounds with a large plastic boot to the right shin/lower leg and foot that was estimated to be approximately 6-8 pounds. The resident was surprised and upset at the weight of 164 pounds and stated he has never weighed below 160 pounds and requested nutrition interventions. On 09/26/24 the facility's RD submitted documentation to the surveyor that included: * The resident had a significant weight loss of 25 pounds in one week. * Health Shake (twice daily) BID (400 calories, 12 grams Protein). * Double Entree Portions (all meals). * Daily Scheduled Snacks ((2 PM and HS). * Continue Pro-Stat(R) AWC (Advanced Wound Care) BID (200 calories, 34 grams Protein). * Continue to monitor weights and intake

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41837 Based on observations, interviews and record review the facility failed to ensure physician's orders for tube feeding were followed for 2 of 3 residents reviewed for tube feeding (Residents #18 and #85) The findings included: On 09/23/24 at 11:45 AM an observation was made of Resident #85 lying in bed with bottle of Glucerna 1.2 (formula type) tube feeding at the 800 milliliter mark out of a 1,000 milliliter capacity bottle. The bottle was labeled as started at 09/23/24 at 6:00 AM, the tube feeding was not infusing. On 09/24/24 at 8:30 AM an observation made of Resident #85 lying in bed with bottle of Glucerna 1.2 tube feeding just above the 900 mark out of a 1,000 milliliter capacity bottle. The bottle was labeled as started at 09/24/24 at 5:45 AM the tube feeding was infusing at 70 milliliters per hour. On 09/24/24 at 1:45 PM an observation was made of Resident #85 lying in bed with bottle of Glucerna 1.2 tube feeding just below the 800 mark out of a 1,000 milliliter capacity bottle. The bottle was labeled as started at 09/24/24 at 5:45 AM the tube feeding was not infusing. In summary this indicated the resident had received only 1,100 milliliters of tube feeding in 24 hours, not 1,400 milliliters as per physician's order. Record review for Resident #85 revealed the resident was originally admitted to the facility on [DATE] with readmission on 09/22/23 with diagnoses that included in part the following: Unspecified Sequelae of Cerebral Infarction, Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side, Dysphagia Following Cerebral Infarction, and Gastrostomy Status. Review of the Minimum Data Set (MDS) for Resident #85 dated 07/02/24 documented in Section C a Brief Interview of Mental Status (BIMS) could not be conducted due to the resident is rarely/never understood. Review of the order dated 07/16/24 for every shift Glucerna 1.2 @ 70 ml/hr (hour) X 20 hrs via PEG. OFF at 10:00 AM and ON at 2:00 PM or until 1400 ml is infused within 24 hrs. Review of the Progress notes from 09/23/24 to 09/24/24 for Resident #85 revealed there was no documentation of the tube feeding stopped between 2:00 PM and 10:00 AM. During an interview conducted on 09/25/24 at 11:15 AM with Staff B Licensed Practical Nurse who stated he has worked at the facility for 3 months. When asked if he calculates the amount of the tube feeding for any resident receiving tube feeding, he said they cannot calculate the total amount of tube feeding because the bottle is changed out on the evening shift. 2) On 09/23/24 at 9:40 AM an observation was made of Resident # 18 with Glucerna 1.2 (formulary type) tube feeding at the 950 mark out of a 1,000 milliliter capacity bottle. the bottle was labeled as being started on 09/23/24 at 5:00 AM and was infusing via pump at 70 milliliters per hour. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105903	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Azure Shores Rehab	800 NW 95th Street Miami, FL 33150

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/24/24 at 1:40 PM an observation was made of Resident #18 with Glucerna 1.2 (formulary type) tube feeding between the 900 mark out of a 1,000 milliliter capacity bottle. the bottle was labeled as being started on 09/24/24 at 5:55 AM and was not infusing. In summary this indicated the resident had received only 1,000 milliliters of tube feeding in 24 hours, not the 1,400 milliliters as per physician's order. Record review for Resident #18 revealed the resident was originally admitted to the facility on [DATE] with the most recent readmission on 06/17/24 with diagnoses that included in part the following: Unspecified Sequelae of Cerebral Infarction, Dysphagia Following Cerebral Infarction, and Gastrostomy Status. Review of the MDS for Resident #18 dated 08/01/24 revealed in Section C a BIMS score of 5 indicating severe cognitive impairment. Review of the Physician's Orders for Resident #18 revealed an order dated 06/17/24 for every shift Glucerna 1.2 @ 70 ml/hr x 20 hr via PEG. OFF at 10:00 AM and ON at 2:00 PM, or when 1400 ml delivered in 24 hrs. During an interview conducted on 09/25.24 at 11:10 AM with Staff C Registered Nurse (RN) who stated she has worked at the facility for about 3 months. When asked how she knows if the resident who is receiving tube feeding get the full amount, she said she never calculated the full amount, she just makes sure it is running at the correct rate and turns off the tube feeding from 10:00 AM to 2:00 PM. During an interview conducted on 09/25/24 at 1:20 PM with the Registered Dietician who was asked if she monitors the residents who receive tube feeding, she said yes, she periodically checks the residents tube feeding to make sure it is the correct formula and infusing at the correct rate. When asked how she knows if the residents receive the full amount of tube feeding, she said as long as the tube feeding is running at the correct rate from 2:00 PM to 10:00 AM the following day it would be the full amount. When brought to her attention the observations for Resident #85 and #18, she acknowledged the residents did not receive the full amount of the tube feeding. She further revealed the nurses do not document the amount of tube feeding infused.

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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** 41837 Based on observations, interview and record review the facility failed provide pharmaceutical services to ensure the accurate administering and documenting of medications to meet the needs of each resident for 1 of 4 resident reviewed for medication administration observation (Resident #54) and for 2 of 9 residents reviewed for controlled medications (Residents #6, and #54), and failed to ensure a discontinued medication was removed from the med cart for 1 of 9 residents reviewed during med reconciliation review (Resident #6) The findings included: Record review for Resident #54 revealed the resident was originally admitted to the facility on [DATE] with the most recent readmission on 08/16/23 with diagnoses that included in part the following: Spondylosis Lumbar Region, Respiratory Disorders in Diseases Classified Elsewhere, Chronic Obstructive Pulmonary Disease (COPD), Type 2 Diabetes Mellitus, Acquired Absence of Left Leg Below Knee, Other Specified Depressive Episodes, Peripheral Vascular Disease, and Bipolar Disorder. Review of the Minimum Data Set (MDS) for Resident #54 dated 07/09/24 documented in Section C a Brief Interview of Mental Status score of 14 indicating a cognitive response. Review of the Physician's Orders for Resident #54 revealed an order dated 02/20/24 for Gabapentin Capsule 100 milligram (mg) give 1 capsule by mouth three times a day for Peripheral Neuropathy. Review of the Physician's Orders for Resident #54 revealed an order dated 04/23/24 for Ascorbic Acid Tablet 500 mg(milligrams) give 1 tablet by mouth one time a day for wound care management. Review of the Physician's Orders for Resident #54 revealed an order dated 08/16/23 Multiple Vitamins with Minerals Tablet give 1 tablet by mouth one time a day for Wound Healing Review of the Physician's Orders for Resident #54 revealed an order dated 08/19/24 for Aspirin EC (Enteric Coated) Tablet Delayed Release 81 mg give 1 tablet by mouth one time a day for PVD (Peripheral Vascular Disease) give 1 tablet by mouth one time a day for PVD Review of the Physician's Orders for Resident #54 revealed an order dated 08/28/24 for Spiriva Respimat Inhalation Aerosol Solution 2.5 mcg/ACT (Tiotropium Bromide Monohydrate)1 puff inhale orally one time a day for COPD. Review of the Physician's Orders for Resident #54 revealed an order dated 09/04/24 for Seroquel oral tablet 300 mg (Quetiapine Fumarate) give 1 tablet by mouth two times a day for Bipolar. Review of the Physician's Orders for Resident #54 revealed an order dated 08/16/24 for Lamotrigine Tablet 100 MG Give 1 tablet by mouth two times a day for Bipolar. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Physician's Orders for Resident #54 revealed an order dated 08/16/23 for Empagliflozin-Metformin HCl ER (Synjardy) oral tablet Extended Release 24 Hour 25-1000 mg (Empagliflozin-Metformin HCl) give 1 tablet by mouth one time a day for DM Review of the Physician's Orders for Resident #54 revealed an order dated 08/16/23 for Clopidogrel Bisulfate Tablet 75 mg give 1 tablet by mouth one time a day for blood clot prevention. Review of the Physician's Orders for Resident #54 revealed an order dated 08/16/23 for Fluoxetine HCl Capsule 720mg give 2 capsules by mouth one time a day for depression. Review of the Physician's Orders for Resident #54 revealed an order dated 11/09/23 for Oxycodone-Acetaminophen Tablet 5-325 mg give 1 tablet by mouth every 6 hours as needed for pain Review of the Physician's Orders for Resident #54 revealed an order dated 08/28/24 for Breo Ellipta Inhalation Aerosol Powder Breath Activated 100-25 mcg/ACT (Fluticasone Furoate-Vilanterol) 1 puff inhale orally one time a day for obstructive pulmonary disease. Review of the behaviors for Resident #54 from 09/01/24 to 09/23/24 revealed no documentation of behaviors observed by staff. Review of the Medication Administration Audit Report for Resident #54 for 09/23/24 revealed the following medications were documented as being administered as follows: 9:44 AM Gabapentin 100 mg 9:46 AM Multi vitamin with iron 9:47 AM Synjardy XR 25-1,000 mg Not documented as administered Oxycodone/Apap (Percocet) 5/325 mg 9:56 AM Breo Ellipta inhaler 100-250 10:04 AM Aspirin EC 81 mg 9:58 AM Clopidogrel Bisulfate 75 mg 9:58 AM Fluoxetine 20 mg 9:58 AM Lamotrigine 100 mg 9:58 AM Spiriva Respimat Inhalation Aerosol Solution 2.5 mcg/ACT 9:58 AM Seroquel 300 mg 9:58 AM Ascorbic Acid 500 mg (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/23/24 at 9:45 AM a med pass observation was conducted with Staff D Licensed Practical Nurse (LPN) for Resident # 54. The LPN prepared the following medications after using hand sanitizer: Gabapentin 100 mg Multi vitamin with iron Synjardy XR 25-1,000 mg The LPN verified with the surveyor there were 3 pills in the medication cup. When asked if this was the only medications the resident was due to be given at this time, she said yes. The LPN administered the medications to Resident #54 without asking the resident his name, date of birth, checking his wrist band, or verify with another staff member the identity of the resident. During the administration of the 3 medications to Resident #54, the resident informed the LPN he needed his inhaler and Percocet. The LPN returned to the med cart did not perform hand hygiene and prepared the following medications: Oxycodone/Apap (Percocet) 5/325 mg Breo Ellipta inhaler 100-250 The LPN entered the resident's room and applied a pair of gloves without performing hand hygiene, and again the LPN administered the medications without asking the resident his name, date of birth, check his wrist band, or verify with another staff member the identity of the resident. The LPN administered the medications, and did not have the resident rinse his mouth after using the inhaler. The LPN removed her gloves and did not perform hand hygiene. During an interview conducted on 09/23/24 at 10:00 AM with Staff D LPN who was asked about hand hygiene, she acknowledged she forgot to do hand hygiene when she removed her gloves. When asked about the Breo inhaler, if the resident should rinse his mouth after use, she said: I don't think so. When the LPN was asked to read the Breo packaging, she acknowledged she should have offered water for the resident to rinse his mouth as it is stated on the Breo Ellipta packaging. During an interview conducted on 09/23/24 at 12:50 PM with Resident #54 who was asked if he received any medications from his nurse today before or after the medications given were observed being administered by his nurse with this surveyor present, he said no. During an interview conducted on 09/23/24 at 12:58 PM with Staff D LPN was asked if she had administered any medications to Resident #54 before or after the mediation administration observations earlier today with Resident #54, she said no she did not. When asked why there were other medications for Resident #54 scheduled at 9:00 AM and documented as being administered by her today, she did not answer the question, she simply said: I went in twice with you to pass his medications, I did not give him any other medications. During an interview conducted on 09/25/24 at 8:45 AM with the Director Of Nursing (DON) who stated Staff D LPN had made a mistake with the med pass on 09/23/24 with Resident #54. The DON said she was a new nurse and had gotten nervous and marked the medications as administered when she had not administered them. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) Review of the Physician's orders for Resident #54 revealed an order dated 11/09/23 for Oxycodone-Acetaminophen 5-325 mg tablet give 1 tablet by mouth every 6 hours as needed for pain. On 09/25/24 at 1:50 PM a med cart review of the 400/600 med cart with Staff B Licensed Practical Nurse (LPN) which included a review of the medication Oxycodone/APAP 5/325mg for Resident #54 which had a remaining count of 21 pills. The Medication Monitoring/Control Log indicated the medication Oxycodone/APAP 5/325mg was removed on the following days/times: 09/23/24 at 10:00 AM 09/23/24 at 6:32 AM 09/23/24 at 12:05 PM Review of Medication Administration Record (MAR) for Resident #54 for 09/23/24 documented the medication Oxycodone/APAP 5/325mg was not administered. 3) Review of the Physician's Orders for Resident #6 revealed an order dated 04/26/24 for Tramadol HCl Oral Tablet 50mg give 1 tablet by mouth every 6 hours as needed for Pain and was discontinued on 06/03/24. On 09/25/24 at 2:15 PM a med cart review of the 300-med cart with Staff E Registered Nurse which included a review of the medication Tramadol 50mg for Resident #6 which had a remaining count of 19 pills. The Medication Monitoring/Control Log indicated the medication Tramadol 50 mg was removed on the following days/times: 06/07/24 7:00 PM 06/18/24 8:40 AM 06/18/24 11:00 AM 06/19/24 at 1:00 PM 07/03/24 at 4:00 PM This indicated the medication Tramadol 50 mg was removed 5 times after the medication was discontinued and the discontinued medication remained in the med cart for over 4 months after it was discontinued. Review of MAR for Resident #6 from 06/01/24 to 07/03/24 revealed no documentation for the Tramadol 50 mg being administered. During an interview conducted on 09/25/24 at 2:16 PM with Staff H LPN who stated she has worked at the facility for about 2 months. When asked what the process is for administering a controlled substance, she stated we check to see if there is an order, make a note, bingo card matches computer, after administration sign off on MAR and narcotic sheet and make sure the count is correct. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview conducted on 09/25/24 at 2:18 PM with the Director of Nursing (DON) who was asked about the process for removing and administering a controlled substance, the DON stated the nurse verifies the order for the resident, will remove the medication from the med cart, document the removal on the Control Log, administer the medication then document the administration of the medication in the resident's electronic medical record on the MAR. When asked about the process when a controlled medication is discontinued, the DON stated once a medication is discontinued, the nurse should remove the medication from the med cart to be returned to the pharmacy. The Unit Manager audits the med carts weekly to ensure no discontinued meds are in the med carts. The DON helps out with the return of the discontinued medication being returned to pharmacy. When asked about Resident #54 and the Medication Monitoring/Control Log and the medication administration times for Oxycodone-Acetaminophen 5-325mg tablet, the DON acknowledged the nurse(s) who removed the medication did not document the medication was administered. When asked about Resident #6 and the Medication Monitoring/Control Log and the medication administration times for Tramadol 50mg, the DON acknowledged the nurse(s) who removed the medication did not document the medication was administered. The DON also acknowledged the Tramadol 50 mg for Resident #6 had been discontinued on 06/03/24 and should have been removed from the med cart at that time. Review of the facility's policy titled, Administering Medications with a revised date of 02/21/23 included the following in part: 3. Medications are administered in accordance with prescriber orders, and current standards of practice. a. Staff follows established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications as applicable. 7. The individual administering medication verifies the resident's identity (using 2 forms) before giving the resident his/her medications. Methods of identifying the resident include: a. Checking identification band. b. Checking photograph attached to medical record; and c. If necessary, verify resident identification with other facility personnel. 19. If a drug is withheld, refused or given at a time other than the scheduled time, the individual administering the medication shall enter the correct code in the box on EMAR followed by nursing note if indicated. 21. As required or indicated for a medication, the individual administering the medication records in the resident's medical record: a. The date and time the medication was administered. Review of the facility's policy titled, 4.0 Schedule II Controlled Substance Medication with not effective dated list included the following in part: H. Dispensing of Controlled Dangerous Substances (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Solid oral doses (capsules, tablets, etc.) will be dispensed in a reverse number of packs or bingo cards. 3. A declining inventory sheet will be provided with each dispensed prescription for dangerous medications. The form will contain the following information: patient name, medication name, medication strength, dosage form, name of prescribing physician, amount dispensed, prescription number and date dispensed. I. Discontinuation of Controlled Substances 1. Controlled medication which have been discontinued due to physician order, patient discharge, or patient death, must be destroyed per facility policy. Review of the facility's policy titled, Hand Hygiene with a revised date of 02/05/23 included the following in part: 1 All staff should perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice. 2 Reference the table below for conditions and indications where hand hygiene is required. Before applying and after removing personal protective equipment (PPE), including gloves - Use either soap and water or alcohol-based hand rub 60% or higher (ABHR is preferred). Before preparing for or handling medications - Use either soap and water or alcohol-based hand rub 60% or higher (ABHR is preferred).

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	105903	A. Building B. Wing	09/26/2024

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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 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** 41837 Based on observations, interviews, and record review the facility failed to ensure the medication error rate was not 5% or greater. The medication error rate was 28% with 7 medication errors identified while observing a total of 25 opportunities, affecting Resident #54. The findings included: Record review for Resident #54 revealed the resident was originally admitted to the facility on [DATE] with the most recent readmission on 08/16/23 with diagnoses that included in part the following: Spondylosis Lumbar Region, Respiratory Disorders in Diseases Classified Elsewhere, Chronic Obstructive Pulmonary Disease (COPD), Type 2 Diabetes Mellitus, Acquired Absence of Left Leg Below Knee, Other Specified Depressive Episodes, Peripheral Vascular Disease, and Bipolar Disorder. Review of the Minimum Data Set (MDS) for Resident #54 dated 07/09/24 documented in Section C a Brief Interview of Mental Status score of 14 indicating a cognitive response. Review of the Physician's Orders for Resident #54 revealed the following medication orders: an order dated 08/16/23 Multiple Vitamins with Minerals Tablet give 1 tablet by mouth one time a day for Wound Healing an order dated 08/16/23 for Empagliflozin-Metformin HCl ER (Synjardy) oral tablet Extended Release 24 Hour 25-1000 mg (Empagliflozin-Metformin HCl) give 1 tablet by mouth one time a day for DM Order dated 08/16/23 for Clopidogrel Bisulfate Tablet 75 mg (milligram) give 1 tablet by mouth one time a day for blood clot prevention. Order dated 08/16/23 for Fluoxetine HCl Capsule 20 mg give 2 capsules by mouth one time a day for depression. Order dated 11/09/23 for Oxycodone-Acetaminophen Tablet 5-325 mg; give 1 tablet by mouth every 6 hours as needed for Pain. Order dated 02/20/24 for Gabapentin Capsule 100 mg; give 1 capsule by mouth three times a day for Peripheral Neuropathy. Order dated 04/23/24 for Ascorbic Acid Tablet 500 mg; give 1 tablet by mouth one time a day for wound care management. Order dated 08/16/24 for Lamotrigine Tablet 100 mg; give 1 tablet by mouth two times a day for Bipolar. Order dated 08/19/24 for Aspirin EC (Enteric Coated) Tablet Delayed Release 81 mg; give 1 tablet by mouth one time a day for PVD (Peripheral Vascular Disease). (continued on next page)

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	105903	A. Building B. Wing	09/26/2024

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Order dated 08/28/24 for Breo Ellipta Inhalation Aerosol Powder Breath Activated 100-25 mcg/ACT (Fluticasone Furoate-Vilanterol) 1 puff inhale orally one time a day for obstructive pulmonary disease. Order dated 08/28/24 for Spiriva Respimat Inhalation Aerosol Solution 2.5 mcg/ACT (Tiotropium Bromide Monohydrate)1 puff inhale orally one time a day for COPD. Order dated 09/04/24 for Seroquel oral tablet 300 mg (Quetiapine Fumarate); give 1 tablet by mouth two times a day for Bipolar. Order dated 08/16/24 for Lamotrigine Tablet 100 mg; give 1 tablet by mouth two times a day for Bipolar. Review of the Medication Admin Audit Report for Resident #54 for 09/23/24 revealed the following medications were documented as being administered as follows: 9:44 AM Gabapentin 100 mg 9:46 AM Multi vit with iron 9:47 AM Synjardy XR 25-1,000 mg Not documented as administered Oxycodone/apap (Percocet) 5/325 mg 9:56 AM Breo Ellipta inhaler 100-250 10:04 AM Aspirin EC 81 mg 9:58 AM Clopidogrel Bisulfate 75 mg 9:58 AM Fluoxetine 20 mg 9:58 AM Lamotrigine 100 mg 9:58 AM Spiriva Respimat Inhalation Aerosol Solution 2.5 mcg/ACT 9:58 AM Seroquel 300 mg 9:58 AM Ascorbic Acid 500 mg On 09/23/24 at 9:45 AM a med pass observation was conducted with Staff D Licensed Practical Nurse (LPN) for Resident #54. The LPN prepared the following medications after using hand sanitizer: Gabapentin 100 mg Multi vitamin with iron Synjardy XR 25-1,000 mg (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The LPN verified with the surveyor there were 3 pills in the medication cup. When asked if this was the only medications the resident was due to be given at this time, she said yes. The LPN administered the medications to Resident #54 without asking the resident his name, date of birth, checking his wrist band, or verify with another staff member the identity of the resident. During the administration of the 3 medications to Resident #54, the resident informed the LPN he needed his inhaler and Percocet. The LPN returned to the med cart did not perform hand hygiene and prepared the following medications: Oxycodone/apap (Percocet) 5/325 mg Breo Ellipta inhaler 100-250 The LPN administered the medications, and did not have the resident rinse his mouth after using the inhaler. During an interview conducted on 09/23/24 at 10:00 AM with Staff D LPN who was asked about the Breo inhaler, if the resident should rinse his mouth after use, she said; I don't think so. When the LPN was asked to read the Breo packaging, she acknowledged she should have offered the resident water to rinse his mouth as it is stated on the Breo Ellipta packaging. During an interview conducted on 09/23/24 at 12:50 PM with Resident #54 who was asked if he received any medications from his nurse today before or after the medications that were observed administered by his nurse with this surveyor present, he said no. During an interview conducted on 09/23/24 at 12:58 PM with Staff D LPN who was asked if she had administered any medications to Resident #54 before or after the mediation administration observations earlier today with Resident #54, she said no she did not. When asked why there were other medications for Resident #54 scheduled at 9:00 AM and documented as being administered by her today, she did not answer the question, she simply said: I went in twice with you to pass his medications, I did not give him any other medications. During an interview conducted on 09/25/24 at 8:45 AM with the DON who stated Staff D LPN had made a mistake with the med pass on 09/23/24 with Resident #54. The DON said she was a new nurse and had gotten nervous and marked the medications as administered when she had not administered them.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105903	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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. 41837 Based on observations, interview the facility failed to ensure all disposed medications are stored in a secure manner for 1 of 4 residents observed during med administration (Resident #54). The findings included: On 09/23/24 at 9:45 AM an observation of med administration with Staff D Licensed Practical Nurse (LPN) for Resident #54 was conducted. While preparing the medications for Resident #54, the nurse spilled a pill out of the med cup and put the pill into the uncovered trash bin located on the side of the med cart. During an interview conducted on 09/23/24 at 10:00 AM with Staff D LPN who stated she has worked at the facility for 1 month and she is a new graduate nurse. When asked about drug disposal, the LPN stated the medication should go in the drug buster that is located on her cart in the bottom drawer. The LPN acknowledged she did not dispose of the medication properly.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 01948 Based on observation, interview, and record review, it was determined that the facility's menu failed to meet the nutritional needs for 28 facility residents (included Sampled Resident's #21, #57, #65, #69, #76, #97, #102 and #140) residents with physician ordered Dysphagia Advanced/Dysphagia Mechanical Soft, and 9 facility resident's (included Sampled Resident's #53, #58, #59, and #95) with physician ordered Dysphagia Pureed. The findings included: During the review of the approved menu for the Lunch meal for 09/24/24, the following were noted: Lettuce & Tomato Plate (4 ounces) and Pickle Spear (1) to be server to Regular diet. Further review noted that there was no planned vegetable substitution documented for Dysphagia Advanced Diet, Dysphagia Mechanical Soft Diet, and Dysphagia Pureed Diet. Interview with the Corporate Food Service Director (CFSD) at the time of the review confirmed diets failed to have a documented vegetable substitution planned on the approved menu. It was discussed with the CFSD that the menu failed to meet the nutritional requirements for vegetable serving for the day on 09/24/25 and that a planned vegetable such as a vegetable Juice, Tomato Juice, or Pureed cold (lettuce) or hot vegetable should have been planned into the approved lunch menu. The CFSD stated that there was an error in the planned approved menu and that he would contact his corporation for clarification. Review of the facility's Diet Census for 09/24/24 noted there were twenty eight facility residents with physician ordered Dysphagia Advanced/Dysphagia Diet, Mechanical Soft Diet, and nine facility resident's with physician ordered Dysphagia Pureed Diet.

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	105903	A. Building B. Wing	09/26/2024

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 01948 Based on observation, interview, and record review, it was determined that the facility failed to prepare foods by methods that conserve nutritive value, palatable flavor and appearance for Dysphagia Mechanically Altered Diet, Mechanical Soft Diet, Dysphagia Pureed Diet, and Regular Diet . The findings included: 1) During the initial dietary/food service observation tour conducted on 09/23/24 at 8:45 AM accompanied with the Corporate Food Service Director (CFSD) , it was noted that quarter and half pans of prepared foods were located within the steamer , however the unit was not on. Further observation noted that the steamer contained fully cooked/prepared foods that included the following half pan of Ground Chicken, half pan of Pureed Chicken, quarter pan Pureed Rice, quarter pan Pureed Macaroni Noodles, half pan Purred Spinach, and quarter pan Pureed Carrots. Further observation noted that the foods appeared non-appetizing and tasteless when tested by the surveyor. Interview with the breakfast/lunch cook (Staff I) revealed the ground and pureed foods were prepared in the early morning hours of 09/23/24 and are held under steam heat until the lunch serving time of 11:30 AM. It was further noted that the foods would be cooked and held for 4 hours until the lunch service and would loose much of their nutrient content as well as appearance and palatability. Staff I stated that the food is prepared in this manner on a daily basis no education had been received on food preparation technique. Following the interview the CFSD stated to the survey that this method of food preparation is not acceptable and not allowed. The CFSD directed Staff to discard all of the prepared ground and pureed foods that were located in the steamer and start with fresh menu foods prepared close to the lunch serving time of 11:30 AM. During the screening process of facility residents on 09/23-24/24 it was noted numerous residents complained of poor quality foods, poor taste and palatability of foods, and poor temperature of served foods. A review of the diet census for 09/23/25 noted that there were currently 28 residents with Dysphagia Advanced and Dysphagia Mechanical Soft Diet. It was also noted that there were currently 9 residents with physician ordered Dysphagia Pureed diet. A review of the facility's Diet Census for 09/23/24 noted that there were currently 28 facility residents with physician ordered Dysphagia Mechanically Altered and Mechanical Soft Diet that included Sampled Residents # 21, #24, #57, #65, #76, #97, #102, and #104, and 9 physician ordered Dysphagia Pureed which included sampled Resident's #53, #58, #59, and 95. 2) During the review of the facility's standardized recipe for the preparation of Eggs, Scramble with Cheese (Liquid/Milk) on 09/24/24 the following were noted: Ingredients: Pasteurized Whole Liquid Eggs (5.58 quarts) Milk 2% (7/8 quart) (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Shredded Cheddar Cheese (2.75 lb) Ground [NAME] Pepper (1.78 Tsp) Procedures: Combine egg mixture, pepper, milk with wire whip Add grated Cheese Cook on griddle or frying pan over low heat until eggs set Serve with #16 scoop During the observation of the breakfast meal in the main kitchen on 09/24/24 at 7:15 AM and accompanied with the CFSD it was noted that the approved menu for meal included the entree of Scramble Eggs with Cheese. Observation of the Egg Entree in the steam table noted that there were large pieces of cheese that had not melted and incorporated into the eggs, the eggs were undercooked (runny) with large pieces of black mold type matter and/or black carbon from the preparation pan in the egg mixture. The surveyor discussed with the CFSD that the eggs were not prepared according to the standardized recipe for Scrambled Eggs with Cheese. It was also discussed with the CFSD the black matter in the egg mixture that could not be identified. The surveyor requested to the CFSD that the egg and cheese entree not be served. * Photographic Evidence Obtained A review of the diet census for 09/23/24 noted that there was the potential that 104 of the 116 resident census would have potentially been served the egg and cheese entree.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 01948 Based on observation, interview, and record review, it was determined that the facility failed to prepare food in a Mechanically Altered and Pureed Form designed to meet resident needs for 28 (Includes Sampled Resident's # 21, #24, #57, #65, #69, #76, #97, #102, and #04) physician ordered Mechanically Altered Diet, and 9 (Includes Sampled Resident's #53, #58, 59, and #95) physician ordered Dysphagia Pureed Diet. The findings included: During the review of the facility's approved Diet and Nutrition Care Manual - Chapter 2: Consistency Alterations 2-16, 2019 .Noted the following: (A) Mechanically Altered (Level 2) of Mechanical Soft Diet: This diet is used for residents with mild to moderate oral and/or pharyngeal dysphagia. Some chewing is required and difficult to chew foods that are chopped, ground, shredded, cooked, or altered to make it easier to chew and swallow. Foods should be soft and moist enough to form a bolus. (B) Dysphagia Puree (Level 1) Diet: The diet is used for resident who have sever chewing and/or swallowing problems. All foods are pureed to simulate a soft food bolus, eliminating the whole chewing phase. All foods must be of the consistency of moist mashed potatoes or puddings During the observation of the lunch meal on 09/24/24 at 11:15 AM and accompanied by the Corporate Food Services Detain (CFSD), it was noted that the approved menu documented the entree of Ground BBQ Cheeseburger be served to Dysphagia Advanced and Dysphagia Mechanical Soft Diets. Observation of the lunch tray of 09/24/24 noted the following: (a) The half steam pan of the Ground BBQ Cheeseburger was noted watery and thin, and diluted with too much mater. When served on a plate it was noted that the ground mixture turned into a large puddle of brown substance. A taste test of the ground mixture conducted by the surveyor confirmed lack of palatability and taste. The CFSD agreed with the surveyor's findings and requested Staff I prepare fresh entree with proper ground preparation techniques. Staff additionally stated that the food is not tasted prior to serving. Following the observation, it was concluded by the surveyor with the CFSD that the Dysphagia Mechanically Altered Diet foods and Mechanical Soft Diet foods were not prepared according to physician orders and the facility's Approved Diet Manual. (Photographic Evidence Obtained) (continued on next page)

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	105903	A. Building B. Wing	09/26/2024

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(b) The quarter steam table pan of Pureed BBQ Cheeseburger was observed by the surveyor and CFSD with visible pieces of ground beef noted in the mixture. The puree was tasted by the surveyor and CFSD and confirmed that the pureed mixture was not pureed to the required smooth consistency and that Staff I was not aware that pureed foods must be prepared to a smooth consistency to prevent resident choking and potential aspiration. Staff I stated that she has not received education on the proper method of preparing pureed foods,. Following the observation, it was concluded by the surveyor with the CFSD that the Dysphagia Puree Diet foods and Mechanical Soft Diets foods were not prepared according to physician orders and the facility's Approved Diet Manual. (Photographic Evidence Obtained) (c) A review of the facility's Diet Census for 09/23/24 noted the following: * There were currently 28 facility residents' with physician ordered Dysphagia Mechanically Altered and Mechanical Soft Diet. The 28 resident's included Sampled Resident's # 21, #24, #57, #65, #69, #76, #97, #102, and #04. * There were currently 9 facility residents' with physician ordered Dysphagia Pureed Diet. The 9 resident's included Sampled Resident's #53, #58, #59, and 95.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 01948 Based on observation, interview, and record review, it was determined that the facility failed to ensure that a therapeutic diet of Lactose Intolerance/No Dairy was obtained from the attending physician and followed by the facility for 1 (Resident #324) of 5 residents sample for nutrition review. The findings included. On 09/25/24 at 9:00 AM during observation of Resident #324 in his room the resident appeared to be underweight/malnourished, but was alert and oriented. Observation of the breakfast tray noted the tray ticket document NO Dairy/Double Entree Portions, however the food tray contained an 8-ounce carton of whole milk and a single portion of sausage gravy that the ingredients include whole milk. The resident at the time of the observation stated he became Lactose intolerant approximately 5 years ago and has suffered weight loose due to the side effects of being Lactose Intolerant and receives milk and foods made with milk for almost all meals served. Resident #324 revealed he continuously spoke to staff concerning his Lactose Intolerance and receiving milk and food prepared with milk. The resident further stated that his appetite and food intake is very poor. During the 09/25/24 observation; the surveyor requested the Corporate Food Service Director (CFSD) to the room of Resident #324 to view the meal tray served and the resident's concerns. The CFSD confirmed that milk and food prepared with milk were served on the 09/25/24 breakfast tray and confirmed the resident again stated he receives milk and foods prepared with milk for numerous meals. The CFSD also confirmed that the meal tray ticket documented NO DAIRY/DOUBLE PORTIONS. Review of Resident #324's clinical records revealed an original admitted [DATE], discharge date of [DATE], and readmitted [DATE]. Review of admission diagnoses noted Necrosis of Toes, Difficulty Walking, Peripheral vascular disease (PVD), Surgical Aftercare, and Weight Loss. It was noted that there was no physician diagnoses noted in the clinical record for Lactose Intolerance. Review of current physician orders noted no diet order for Lactose Free /No Milk of Milk Products and the diet order was for only No Added Salt/Double Entree. It was also noted that Between meal snacks at 2:00 PM and HS (bedtime) were discontinued on 09/22/24. A review of the resident's weight history noted a weight of 92 pounds recorded on 09/12/24 with a BMI of 14 (Malnutrition), height of 68 inches Record review on 09/25/24 of the Nutrition assessment dated [DATE] documented the resident stated to be Lactose Intolerant, Usual Body Weight (UBW) of 120 pounds, Ideal Body Weight of 151 pounds. Resident consuming 50-75% of meals, and a summary assessment of Protein Calorie Malnutrition -Severe Underweight. A review of the current Care Plan dated 09/21/24 documented Nutritional Problem due to weight loss and lactose intolerant. The facility's Registered Dietitian following the record review of 09/25/24 noted that the attending physician failed to document a primary diagnoses of lactose Intolerant and failed to order a Lactose Free and No Dairy Diet for Resident #324. It was also discussed with the Registered Dietitian of the potential need to obtain a proper Lactose free diagnoses, Lactose free Diet, and potentially the need to obtain an order for an appetite stimulant. (continued on next page)

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	105903	A. Building B. Wing	09/26/2024

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/26/24 the surveyor noticed a visitor leaving the room of Resident #324. The surveyor was able to identify the visitor as a sibling who stated the resident has suffered with Lactose Intolerance and weight loss over the past few years. Further stated that the facility constantly serves milk and milk products to the resident resulting in gastric issues. On 09/26/24 the Registered Dietitian (RD) submitted a copy of a Nutrition Note dated 09/25/24 that documented she and the Unit Manager spoke to the physician regarding appetite stimulant and a new order was obtained for Cyproheptadine for 1 month and to begin to monitor weekly weights and oral intake of all meals and diagnoses of Lactose Intolerance. The RD also submitted documentation of a new diet order Lactose Free/Double Entree Portions and snacks at 2:00 PM and HS. The RD also submitted new meal tray tickets which documented diet of - NO DAIRY/LACTOSE/DOUBLE ENTREE PORTIONS, and also documented NO MILK/YOGURT OR CHEESE - Allergies of: Dairy Allergen.

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	105903	A. Building B. Wing	09/26/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 01948 Based on observation and interview, it was determined that the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety for potentially 104 of the 116 residents who eat foods by mouth. The findings included: 1) During the initial dietary/food service observation tour conducted on 09/23/24 at 8:45 AM, and accompanied with the facility's Certified Dietary Manager and Corporate Food Service Director (CFSD), the following were noted: (a) Observation of the cook's preparation sink noted a large cooking pot full of water that contained a 10 pound package of raw chicken. Further observation noted that no cold water was running over the chicken and the CFSD stated that the chicken was thawing, and staff failed to ensure that the cold water was running into the pot at full volume. At the request of the surveyor the temperature of the water within the pot was taken by the CFSD with the facility's calibrated food thermometer and was recorded at 100 degrees Fahrenheit (F). The surveyor reviewed that the regulatory temperature for thawing hazardous foods via cold water was a maximum 70 degrees F. The surveyor requested that the chicken be discarded due to the potential for food born illness if utilized for facility residents. * Photographic Evidence Obtained (b) Observation of the walk-in refrigerator noted that the interior food storage shelving (5) were soiled and in disrepair. It was also noted that the fan covers (2) of the unit were covered with dust. * Photographic Evidence Obtained (c) Observation of ceiling mounted air-conditioning vents (6) located in the food preparation and serving area were noted soiled and covered with a black mold type substance. The surveyor discussed with the CFSD that the black substance could result in food contamination and food borne illness. Photographic Evidence Obtained (d) Observation of the dish machine area noted that the walls behind and around the machine were soiled and covered with a black mold type substance. The surveyor discussed with the CFSD that dish may potentially become contaminated. Photographic Evidence Obtained (e) During the tour it was noted that large areas of the room walls located in food preparation and serving areas were in heavy disrepair. It was noted that at minimum 5 wall areas were in need of repair. * Photographic Evidence Obtained (continued on next page)

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	105903	A. Building B. Wing	09/26/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(f) During the observation of hot and cold temperatures, foods located on the serving steam table were taken with the use of the facility's calibrated food thermometer. The food temperatures were taken by the CFSD and it was noted that hot foods were not being held at the regulatory temperature of 135 degrees F or below as evidenced by the following: * Sausage Patties (12 individual) = 120 degrees F. * French Toast (50 servings) = 125 degrees F. * Pureed Scrambled Eggs with Cheese = 110 F. * Pureed Scrambles Eggs = 120 F. 2) During a second dietary/food service observation conducted of the main kitchen on 09/24/24 at 7:15 AM accompanied with the CFSD the following were noted: (a) During the calibration of the facility's food thermometer it was noted that the thermometer was inaccurate and could not be utilize for food temperature testing. The CFSD stated that a there was not a alternative working food thermometer in the dietary department. The surveyor was forced to utilize the a State issued calibrated thermometer for food temperature testing. (b) Two Certified Nursing Assistants were noted to enter into the food preparation/serving area without gowns, face masks, gloves, and hair restraints. The surveyor requested to the CFSD that the nursing staff leave immediately and discussed that only dietary employees were allowed into the dietary department. The CFSD stated that it was a daily occurrence. 3) During a third follow-up kitchen/food service observation tour conducted on 09/24/24 at 11:15 AM and accompanied with the Corporate Food Service Director, the following were noted: (a) Cleaning rags (3) and soiled paper towels were noted to be stored directly on clean food preparation and serving surfaces when not in use. The surveyor reviewed with the CFSD that soiled cleaning cloths are to be stored in a regulatory chemical solution when not in use, and that soiled paper towels should not be used for cleaning and should be thrown away after each use. * Photographic Evidence Obtained (b) During the tour it was noted that a personal staff cell phone was being stored directly on a clean food serving surface. The surveyor discussed with the CFSD that cell phones are highly soiled and cannot be store directly of clean food surfaces. The CFSD identified the phone as belonging to a dietary staff and staff have been in-serviced concerning the issue previously.

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	105903	A. Building B. Wing	09/26/2024

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 01948 Based on observation, record review and interview, it was determined that the facility failed to dispose of garbage and refuse properly that potentially effected all of the 116 facility residents. The findings included: During the kitchen/food service observation tour conducted on 09/23/24 at 8:45 AM and accompanied with the Certified Dietary Manager and Corporate Food Service Director the garbage/refuse noted to have the garbage/trash container with the lid open and had open garbage and trash spewing onto the [NAME] area around the unit. Further observation of the garbage/refuse area noted that the area behind the dumpster was heavily covered in soiled PPE's (gloves, gowns, masks, unidentifiable resident and nursing waste materials, rotting trash and garbage, and presence and evidence insect and rodent activity. It was estimated that the area was approximately 25 feet long and 5 feet wide and a large area of stagnant, fowl, garbage and trash was located at one end. The surveyor requested that the Administration be notified immediately of the area and potential health hazard. On 09/23/26 at 1:00 PM the Administrator met with the surveyor and informed that the area had been terminally cleaned. On 09/25/24 at 11:30 AM the area was again viewed by the surveyor and the facility Infection Control Preventionist and Corporate Registered Nurse. The observation noted that the garbage /refuse area remained in the same condition as observed on 09/23/24. The Administration was again notified of the potential health hazard conditions and stated that incorrect information was obtained from staff during the 09/23/25 observation.

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	105903	A. Building B. Wing	09/26/2024

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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 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. 39026 Based on observations, interview and record review, the facility's Quality Assurance and Performance Improvement Activities (QAPI/QAA) failed to demonstrate effective plan of actions were implemented to correct identified quality deficiencies in the problem area as evidenced by repeated deficient practices for F584, safe, clean, comfortable, homelike environment; F693, tube feeding management; F814, dispose garbage and refuse properly; and F867, QAPI/QAA improvement activities. These repeated deficient practices have the potential to affect all 116 residents residing in the facility at the time of this survey. The findings included: Review of the facility's survey history revealed the facility was cited F584, F693, F814 and F867 during the recertification and Relicensure survey with an exit date of 06/18/23. During an interview with the facility's Administrator on 09/26/24 at 1:05 PM, the Administrator was apprised that these 4 deficiencies will be cited again on this current survey. The Administrator stated he will be working to remedy this.