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	04/09/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and records reviewed it was determined that the facility did not appropriately maintain the Advance Directives for one (101) out of four sampled residents receiving hospice services. Resident # 101's medical record included a signed Do Not Resuscitate form, a physician's order for Full Code and a signed Advanced Directive Acknowledgment form indicating Full Code. There were 119 residents residing in the facility at the time of survey. The findings included: On 04/06/2026 at 11:34 AM Resident #101 was observed in bed, no apparent distress noted.Record review of Resident #101's face sheet revealed the residents was admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis that included but not limited to Acute Myeloblastic Leukemia.Record review of a Quarterly Minimum Data Set reference dated 02/10/2026 indicated Resident #101 had moderate cognitive impairment and receiving hospice care.Record review of Resident #101's care plan initiated on 10/09/2025 and revised on: 04/07/2026 revealed Resident # 101 has Advanced Directives wishes in place for Do Not Resuscitate (DNR) and receiving hospice services. Interventions documented included: We will communicate your Advance Directives wishes to pertinent staff and your wishes will be communicated via orders in medical record.Record review of the March 2026 physicians order sheets revealed Resident #101 had an order dated 2/25/2026 for Full Code and an order dated 03/05/2026 for hospice admission with diagnosis of unspecified B-cell lymphoma.Review of an Advanced Directive Acknowledgment form dated 02/25/2026 indicated Resident # 101 choose Full Code.Review of Resident # 101's hospice binder revealed a list of the hospice team with phone numbers, an initial certification dated 02/27/2026 and physician orders. Review of the Electronic Health Record revealed a yellow signed Do Not Resuscitate form dated 9/17/2025 signed by Resident #101. and the physician. Record review a Social Services note dated 02/27/2026 documented Resident # 101's code status is Full Code. The following Advance Directives are in place: none. Resident is oriented. Resident is involved and participates in activities. During an interview on 04/09/2026 at 11:38 AM the Hospice Social Worker stated: We are working on getting [Resident #101] to sign a DNR. During an interview on 04/09/2026 at 3:51 PM Staff I, Licensed Practical Nurse (LPN) revealed Resident # 101's Advanced Directives is Full code.During an interview on 04/09/2026 at 4:22 PM the Director of Nursing (DON) revealed Resident #101 had a DNR that was signed upon initial admission and upon readmission the resident wanted to be Full Code and signed a Full Code Advance Directive. We keep the DNR in the file because it is part of the medical record. [Resident # 101] spoke with the Social Services Director and confirmed wanting a Full Code Advanced Directive. On 04/09/2026 at 4:34 PM the Social Services Director stated, I was not aware [Resident#101] wanted a Full Code Advanced Directive. I do not know who wrote the Social Services note indicating Resident # 101 wanted an Advanced Directive of Full Code and I do not know who wrote it and signed with my electronic signature. During a telephone interview on 04/09/2026 at 5:00 PM the Hospice nurse revealed, Resident # 101 has an Advanced Directive of Full Code. Record review of the facility's policy titled, Advanced Directives revised on 08/13/2025 revealed Purpose: To honor the advance directives of all residents and to make information available to the resident on how (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
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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to prepare such directives, should the resident not have them in place or to change existing directives.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, records reviewed and interviews, the facility failed to ensure privacy of confidential information on two (medication carts 400/500 and 100) out of five medication carts and during medication administration for one (Resident #32) out of five sampled residents as evidenced by staff left medication bingo card with resident's medical information visible unattended on top of the unattended 400/500 medication cart. Paper census with residents' pictures and medical information visible left unattended on the 100-medication cart and Staff observed administering medications to Resident #32 in the hallway in front of the nursing station. There were 119 residents residing in the facility at the time of the survey.The findings included:Observation on 04/06/2026 at 12:33 PM revealed a bingo card with resident's name and medical information visible on top of the unattended 400/500 medication cart. (photo evidence). On 04/06/2026 at 12:42 PM, the Assistant Director of Nursing (ADON) was interviewed about the facility's policy regarding protecting residents' information and stated, Staff are to ensure any documentation containing resident's information is stored in a way to prevent visibility to anyone outside of the medical care team. On 04/06/2026 at 12:45 PM Staff E, Registered Nurse (RN) was made aware of the identified concern and stated, I turn the bingo cards over for confidentiality. I don't know how I forgot.Observation on 04/07/2026 at 1:13 PM, revealed Resident # 32 being escorted in a wheelchair by two family members towards the elevator on the second floor. Staff E, RN stopped Resident #32 and administered medications, and the resident took the medications.On 04/07/2026 at 1:14 PM Staff E, RN, was interviewed about the facility's policy for providing privacy during medication administration and stated, Medications are to be administered in the rooms for privacy. I administered the medication to [Resident # 32] because I was trying to get to the resident before the resident left the floor. On 04/07/2026 at 4:30 PM the Director of Nursing was made aware of the identified concern and stated, It is not acceptable to administer medications in the hallway. Record review of Resident #32 clinical records revealed the resident was admitted on [DATE] with diagnosis that included: Sequelae of cerebral infarction. Record review of a Quarterly Minimum data set (MDS) reference dated 3/16/2026 revealed Resident #32 had a Brief Interview of Mental Status score of 8 indicating moderate cognitive impairment.Observation on 04/09/2026 at 11:15 AM, a paper census with residents' pictures and medical information visible on top of the First floor 100-section medication cart (photo evidence).On 04/09/2026 at 11:16 AM Staff H, Licensed Practical Nurse returned to the 100-section medication cart and was made aware of the identified concern and stated, I am supposed to turn the paperwork over to protect resident information. Record review of the facility's Policy: Health Information Privacy and Accountability Act (HIPAA) effective date: 04/01/2022 revision date: 11/27/2025 revealed: Purpose: The Center shall protect the privacy of our residents in person and as related to their personal health information and maintain compliance with HIPAA laws in order to protect the privacy of health care information and privacy of the resident.Procedure: 3. All residents are entitled to their privacy as well as the privacy of their medical or financial record.6. Paper notes or reminders with residents' personal or medical information shall not be left unattended or viewable by unauthorized persons. These paper notes and reminders should be disposed of in a way that will not compromise resident's personal or medical information.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility inaccurately coded the Minimum Data Set (MDS) for one (Resident #128) out of three residents closed records reviewed. Staff coded Resident #128, who had expired at the facility, as having been hospitalized in the Minimum Data Set (MDS). At the time of the survey, 119 residents resided in the facility. The findings included. Record review of Resident # 128 clinical records revealed the resident was admitted to the facility on [DATE], readmitted on [DATE] and expired at the facility on [DATE]. Clinical diagnoses included Chronic Obstructive Pulmonary Disease, (COPD), Record review of the Death in Facility Minimum Data Set (MDS) Section A (Identification Information) dated [DATE] documented Resident #128 was discharged to a short-term general hospital.During an interview on [DATE] at 11:50 AM, the MDS Director revealed she had intended to record the resident as deceased , but the system registered the entry under code 4, which is designated for shortˆterm general hospital. On [DATE] at 3:57 PM the Director of Nursing stated that the facility had no written policies or procedures for resident assessment related to coding. Staff relied solely on regulatory guidance, rather than facility-developed protocols.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews the facility's staff failed to implement an oxygen care plan for two (Resident #124 and Resident #13) out of two sampled oxygen dependent residents. Resident #124 and Resident #13 oxygen was being delivered above the prescribed rate. There were 119 residents residing in the facility at the time of survey. The findings include:Resident #124On 04/06/2026 at 9:48 AM Resident #124 was observed in bed with oxygen in progress via nasal cannula at 3.25 Liters Per Minute (LPM). No humidification was observed.Record review of Resident #124's clinical records revealed the resident was initially admitted on [DATE] and readmitted on [DATE] with diagnosis that included: Chronic respiratory failure with hypoxia, Pneumonia, and Dependence on supplemental oxygen.Record review of a physician's order sheet revealed Resident #124 had an order dated 03/6/2026 for oxygen Inhalation via nasal cannula at 2 LPM as tolerated every shift for shortness of breath (SOB) with humidification.Record review of Resident #124 Care Plan initiated on: 09/13/2024 and revised on: 02/11/2026 focus revealed the resident's potential for altered respiratory status/difficulty breathing related to Chronic respiratory failure with history of tracheostomy, recent hospitalization due to respiratory distress from 01/03/2026 to 01/26/2026 readmitted to the facility with interventions that included: Oxygen as ordered.On 04/06/2026 at 2:03 PM Staff E, Registered Nurse (RN) was asked about Resident #124's physician's order for oxygen and notified of the identified concerns; Staff E, RN stated: The physician order is for 2 (LPM). Staff E, RN was and during a side-by-side observation of Resident #124's oxygen flowmeter Staff E, RN stated: It is at 3 LPM. I don't know why.During an interview on 04/09/2026 at 4:24 PM, the Director of Nursing (DON was made aware of the identified concern. The DON stated: The staff are to follow the physician's order when administering oxygen.Resident #13 On 04/06/2026 at 10:07 AM Resident #13 was observed in bed with oxygen in progress at 2.75 LPM via nasal cannula (photo).On 04/06/2026 at 2:02 PM Staff E, RN was observed leaving Resident #13's room and was asked about Resident # 13's current physician's order for oxygen. Staff E, RN verified the physician's order and stated, The order is for 2 Liters per minute. The surveyor made Staff E, RN aware of the identified concern and the surveyor and Staff E, RN entered Resident#13's room and viewed the rate setting on the oxygen flowmeter. Staff E, RN acknowledged the oxygen was not being administered at the prescribed rate.Record review of a demographic sheet revealed Resident #13 was initially admitted on [DATE] and readmitted on [DATE] with diagnosis that included: Acute and Chronic respiratory failure with Hypoxia and Pneumonia.Record review of a physician's order sheet revealed Resident #13 had an order: dated 01/16/2026 for oxygen at 2 Liters via nasal cannula as tolerated every shift related to Acute and Chronic respiratory failure with hypoxia.Record review revealed Resident #13's care plan initiated on: 12/28/2023 and revised on: 01/10/2024 indicated the resident's potential for altered respiratory status/difficulty breathing related to respiratory failure with interventions that included: Oxygen Settings: Oxygen as ordered.Record review of the facility's Policy and Procedure: Clinical-Care Plans. Revised 11/11/2025 revealedPurpose: To ensure the development and implementation of a comprehensive, person-centered care plan that includes measurable objectives and interventions to meet the resident's physical, psychosocial and functional needs. Policy: 1. The Interdisciplinary Team (IDT), in conjunction with the resident/resident representative, develops and implements a comprehensive, person-centered care plan for each resident.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, it was determined that the facility did not update the Advanced Directive Care Plan for one (Resident #101) out of four sampled residents who were receiving hospice services. Resident #101's current care plan did not reflect the resident's Advanced Directive for Full Code documented on the Advance Directive form signed by Resident 101 upon reentry to facility. There were 119 residents residing in the facility at the time of survey.The findings included:On 04/06/2026 at 11:34 AM Resident #101 was observed in bed, no apparent distress and voiced no complaints.Record review of clinical records revealed Resident #101 was admitted on [DATE] and readmitted on [DATE] with diagnosis that included but not limited to: Acute Myeloblastic Leukemia.Record review of a Quarterly minimum data set reference dated 02/10/2026 indicated Resident #101 had moderate cognitive impairment and receiving hospice care.Record review of a March care plan initiated on 10/09/2025 and revised on: 04/07/2026 revealed Resident # 101 has advanced directives wishes in place (DNR) Resident is under Hospice with interventions that included: we will communicate your Advance Directives wishes to pertinent staff and your wishes will be communicated via Order in medical record.Record review of the March 2026 physicians order sheets revealed Resident #101 had orders dated 2/25/2026 for Full Code and 03/05/2026 for Hospice Admit Diagnosis: Unspecified B-cell lymphoma. Record review of an Advanced Directive Acknowledgment form dated 02/25/2026 indicated Resident # 101 choose Full Code.Record review of the Hospice binder belonging to Resident # 101 revealed a hospice team list with phone numbers, an initial certification dated 02/27/2026 and physician orders.Record review of the Electronic Health Record revealed a yellow signed Do Not Resuscitate form dated 9/17/2025 signed by the physician and Resident #101.Record review a Social Services note dated 02/27/2026 revealed Resident # 101's code status is Full Code. The following advance directives are in place: none. Resident is oriented. Resident is involved and participates in activities.During an interview on 04/09/2026 at 11:38 AM the Hospice Social Worker stated: We are working on getting [Resident #101] to sign a DNR.On 04/09/2026 at 3:51 PM Staff I, Licensed Practical Nurse (LPN) revealed Resident # 101's Advanced Directives is Full code.During an interview on 04/09/2026 at 4:22 PM the Director of Nursing (DON) revealed [Resident #101] had a DNR that was signed upon initial admission and upon readmission voiced wanting to be full code and signed a full code advance directive. We keep the DNR in the file because it is part of the medical record. [Resident # 101] spoke with the Social Services Director and confirmed wanting a full code advanced directive.On 04/09/2026 at 4:34 PM the Social Services Director was interviewed and stated, I was not aware [Resident#101] wanted a full code advanced directive. I do not know who wrote the Social Services note indicating Resident # 101 wanted an advanced directive of full code and I do not know who wrote it and signed with my electronic signature.During a telephone interview on 04/09/2026 at 5:00 PM the Hospice nurse revealed, Resident # 101 has an advanced directive of full code.Record review of the facility's Policy and Procedure titled, Clinical-Care Plans Revised 11.11.25 revealed Purpose: To ensure the development and implementation of a comprehensive, person-centered care plan that includes measurable objectives and interventions to meet the resident's physical, psychosocial and functional needs. Policy:The Interdisciplinary Team (IDT), in conjunction with the resident/resident representative, develops and implements a comprehensive, person-centered care plan for each resident.The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.A comprehensive care plan for each resident is developed within seven (7) days of completion of the resident assessment. 7. An explanation should be included in a resident's medical record if the participation of the resident/resident representative for developing the resident's care plan is determined to not be practicable.The care planning process should:Reflect (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident's expressed wishes regarding care and treatment goals.Reflect treatment goals, timetables and objectives in measurable outcomes.

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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. Based on observations, interviews, and record reviews, it was determined that the facility did not consistently maintain an environment free of accident hazards in one of two soiled utility rooms and one of three housekeeping carts. Staff were observed on two occasions failing to secure the soiled utility room door, which housed biohazardous and sharp materials. Additionally, staff were observed twice leaving a housekeeping cart open, with chemicals visible and accessible. These practices presented potential risks to the 119 residents residing in the facility. The findings included:On 04/06/2026 at 10:19 AM an observation was made of an unlocked Soiled Utility room door on the second floor (photo).On 04/06/2026 at 10:27 AM Staff F, Certified Nursing Assistant was observed exiting the Soiled Utility room on the second floor leaving the door unlocked (photo).On 04/06/2026 at 10:28 AM Staff J, Housekeeping observed exiting The Soiled utility room on the second floor second floor and the door remained unlocked.On 04/06/2026 at 10:35 AM, the Assistant Director of Nursing (ADON)/Infection Preventionist was asked about the facility protocol for safety in terms of The Soiled utility room and it was stated: The Soiled utility room door is to be kept locked for infection control and safety of residents. At that time surveyor made the ADON aware of the identified concern.On 04/06/2026 at 10:38 AM Staff D, Registered Nurse (RN) was made aware of the identified concern and stated, The Soiled utility room door is supposed to be locked, and staff enter with a code. It is kept locked for the safety of the residents because there are items that can harm the residents. On 04/06/2026 at 11:20 AM Staff J, Housekeeping was interviewed about identified concern and stated: I did not realize the door was being left open.On 04/06/2026 11:26 AM Staff F, CNA was interviewed about identified concern and stated: The Soiled Utility room door is to be locked and enter with a code. I did not realize the door was remaining unlocked when I exited. I will check next time.On 04/06/2026 at 1:03 PM observation on the 2nd floor, 600 sections hallway revealed Staff L, Floor tech walking away from a housekeeping cart, leaving the cart unlocked and chemical exposed and accessible (photo).On 04/06/2026 on 1:06 PM the Housekeeping Director walked past the open cart and was interviewed about the facility's protocol for safety regarding the housekeeping carts and stated, We have 3 housekeeping carts in the facility, and the carts are to be kept locked when unattended for the safety of residents because there are chemicals in the cart. At that time surveyor made the housekeeping director aware of the identified concern.Interview on 04/06/2026 at 3:21 PM Staff L, Floor tech revealed the cart is to be locked when unattended. The purpose is for the precautions of the residents. I was cleaning and left it unlocked.

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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** Based on observations, records reviewed and interviews the facility staff did not properly position an indwelling urinary tubing to facilitate the flow of urine for one (Resident #101) out of two sampled residents with an indwelling urinary catheter. Loops in Resident #101's indwelling catheter tubing prevented urine from flowing freely, which increased the resident's risk for catheter-associated urinary tract infections and other serious medical issues. At the time of the survey, four residents with indwelling urinary catheters resided in the facilityThe findings included:Resident #101 Observation on 04/06/2026 at 11:34 AM revealed Resident #101 in bed, the indwelling urinary catheter tubing was looped and contained urine (photo).On 04/06/2026 at 12:05 PM Staff D, Registered Nurse (RN) was made aware of the identified concern and observed the Resident #101's indwelling urinary catheter tubing with surveyor. Staff D, RN stated, I will change the position to allow urine to flow to prevent infection. At that time Staff D, RN repositioned catheter tubing to allow the free flow of urine.Resident #101's clinical records revealed the resident was admitted to the facility on [DATE] and readmitted on [DATE]. Clinical diagnoses include but are not limited to: Urinary Tract Infection (UTI).Record review of Resident #101's Care Plans started date 10/09/2025 and revised on 04/07/2026 for an indwelling catheter related to urinary retention with interventions that included: Change urinary catheter as needed, monitor/document for pain/discomfort due to catheter, and monitor/record/report to medical doctor for signs and symptoms of UTI.Review of the Quarterly Minimum Data Set (MDS) reference dated 02/10/2026 revealed Resident #101 had a Brief Interview of Mental Status score of 12 out of 15 which indicated moderate cognitive impairment. Functional status indicated the resident is dependent for toileting hygiene and had an Indwelling catheter.Record review of Resident #101's physician's order sheets revealed an order dated: 03/30/2026 for Levofloxacin oral tablet 500 milligrams (mg) 1 tablet by mouth one time a day for UTI for seven days was completed on 04/06/2026.Record review of the March 2026 medication administration record indicated Resident #101 received Ertapenem Sodium intravenously from 03/11/2026 to 03/17/2026 for a diagnosis of UTI.Review of the April 2026 medication administration record indicated Resident #101 received Levofloxacin from 03/30/2026 to 04/05/2026 for a current UTI. During an interview on 04/06/2026 at 12:40 PM the Infection Preventionist stated: Indwelling urinary catheter tubing should be patent to allow the free flow of urine to prevent infection.Record review of the facility's infection surveillance report for January 1, 2026, to January 31, 2026, revealed the facility had an increase in facility acquired infections indicating that four of six urinary tract/ kidney infections were facility acquired and noted Resident #101 received an antibiotic medication for diagnosis of UTI.Record review of the facility's infection surveillance report for March 1, 2026, to March 31, 2026, revealed the facility had an increase in facility acquired infections with Resident #101 noted to have received an antibiotic medication for UTI. On 04/07/2026 at 10:24 AM Resident #101 was observed in bed, the indwelling urinary catheter tubing had dependent loops with urine in the tubing. On 04/07/2026 at 10:26 AM, the Registered Nurse Supervisor was informed of the identified concern and observed the catheter tubing with the surveyor (photo). At that time Resident #101 moved in bed and the urine that was already in tubing moved upwards inside the tubing. The RN supervisor stated, I didn't know that could happen. The RN supervisor repositioned the catheter tubing to allow urine to flow freely. I will check other catheter tubing to make sure they are positioned properly to prevent back flow of urine. On 04/07/2026 at 11:57 AM Staff F, Certified Nursing Assistant was interviewed about the facility's protocol for positioning the urinary tubing stated: I am the assigned to [Resident #101] today. I position this resident's catheter tubing straight to prevent the urine from going backwards. Record review of the facility's policy titled, Catheter care - Urinary Effective Date: 04/01/22, Revision Date:09/24/25 revealed POLICY: NURSING - CATHETER CARE - URINARY. PURPOSE: The purpose of (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	this procedure is to prevent catheter-associated urinary tract infections.Maintaining Unobstructed Urine FlowCheck 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.Unless specifically ordered, do not apply a clamp to the catheter.The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder.

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Azure Shores Rehab	800 NW 95th Street Miami, FL 33150

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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 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** Based on observations, records review and interviews, the facility failed to ensure oxygen was delivered at the prescribed rate for two (Resident #124 and Resident #13) out of two sampled oxygen dependent residents. The oxygen flowmeters indicated Resident #124 and Resident #13 oxygen was being administered above the prescribed level. There were 119 residents residing in the facility at the time of survey. The findings include:Resident #124 On 04/06/2026 at 9:48 AM Resident #124 was observed in bed with oxygen in progress via nasal cannula at 3.25 Liters Per Minute (LPM). No humidification was observed.Record review of Resident #124's clinical records revealed the resident was initially admitted on [DATE] and readmitted on [DATE] with diagnosis that included: Chronic respiratory failure with hypoxia, Pneumonia, and Dependence on supplemental oxygen.Record review of a physician's order sheet revealed Resident #124 had an order dated 03/6/2026 for oxygen Inhalation via nasal cannula at 2 LPM as tolerated every shift for shortness of breath (SOB) with humidification.Record review of a Quarterly Minimum data set (MDS) reference dated 3/31/2026 revealed Resident #124 had an undetermined Brief Interview of Mental Status (BIMS) score indicating severe cognitive impairment, dependent for Activities of Daily Living (ADL), and received oxygen therapy.Record review of Resident #124's Care Plan initiated 09/13/2024 and revised on: 02/11/2026 revealed the resident's potential for altered respiratory status/difficulty breathing related to Chronic respiratory failure with history of tracheostomy and recent hospitalization due to respiratory distress from 01/03/2026 to 01/26/2026 readmitted to the facility with interventions that included: Oxygen setting as ordered.On 04/06/2026 at 2:03 PM Staff E, Registered Nurse (RN) was asked about Resident #124's physician's order for oxygen and notified of the identified concerns; Staff E, RN stated: The physician order is for 2 (LPM). while viewing Resident #124's oxygen flowmeter Staff E, RN stated: It is at 3 LPM. I don't know why.During an interview on 04/09/2026 at 4:24 PM, the Director of Nursing (DON) was made aware of the identified concern. The DON stated: The staff are to follow the physician's order when administering oxygen. Resident #13 On 04/06/2026 at 10:07 AM Resident #13 was observed in bed with oxygen in progress at 2.75 LPM via nasal cannula (photo).On 04/06/2026 at 2:02 PM Staff E, RN was observed leaving Resident #13's room and was asked about Resident # 13's current physician's order for oxygen. Staff E, RN verified the physician's order and stated, The order is for 2 Liters per minute. The surveyor made Staff E, RN aware of the identified concern and the surveyor and Staff E, RN entered Resident#13's room and viewed the rate setting on the oxygen flowmeter. Staff E, RN acknowledged the oxygen was not being administered at the prescribed rate.Record review of a demographic face sheet revealed Resident #13 was initially admitted on [DATE] and readmitted on [DATE] with diagnosis that included: Acute and Chronic respiratory failure with Hypoxia and Pneumonia.Record review of a significant change in status Minimum Data Set reference dated 01/10/2026 revealed Resident #13's Brief Interview of Mental Status (BIMS) score was undetermined, was dependent for ADLs, received oxygen therapy.Record review of a physician's order sheet revealed Resident#13 had an order: dated 01/16/2026 for oxygen at 2 Liters via nasal cannula as tolerated every shift related to Acute and Chronic respiratory failure with hypoxia.Record review revealed Resident #13's care plan initiated on: 12/28/2023 and revised on: 01/10/2024 indicated the resident's potential for altered respiratory status/difficulty breathing related to respiratory failure with interventions that included: Oxygen Settings: Oxygen as ordered.Record review of the facility's policy titled, Clinical-Oxygen Administration Effective Date 04/01/22 Revision Date 1.26.2026 revealed Policy and Procedure: Clinical Oxygen Administration. Purpose: To provide guidelines for administering oxygen therapy as ordered. Process: 5. Set to the prescribed liter of oxygen to be delivered.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review the facility failed to properly store medications and biologics for two (#132, #116) out of seven sampled residents as evidenced by 1. an observation of two medicated inhalers on the side table of Resident#132. 2. Two observations of a medicated lotion on the nightstand of Resident#116. There were 119 residents residing in the facility at the time of survey. The findings included:Resident #132On 04/06/2026 at 11:37 AM Resident #132 was observed in bed with no apparent distress. Two medicated inhalers were observed inside a plastic bag on the side table next to Resident #132 (photo).On 04/06/2026 at 11:45 AM Staff D, Registered Nurse (RN) stated, Medications are not allowed to be in the rooms. We keep medications in the medication cart. Surveyor notified Staff D, RN of the identified concern and Staff D, RN removed both inhalers from Resident #132's bedside; and S further revealed: There are no physician orders for inhalers. Rounds are made every two hours and any medications observed are removed. I did not see those inhalers next to [Resident #132].Staff F, Certified Nursing Assistant (CNA) was interviewed and stated, I do rounds and if I see any medications at the bedside I inform the nurse.On 04/06/2026 at 12:38 PM, the Assistant Director of Nursing (ADON) was made aware of the identified concern and interviewed about the facility's protocol for storing medications and stated, Medications are kept locked in the medication room and medication carts. Residents are not allowed to keep any medications in their rooms. On 04/06/2026 at 4:14 PM the Director of Nursing was interviewed about the facility's policy for medication storage and stated, Medications are to be properly stored in locked areas. Staff are to do rounds daily to ensure the removal of any medications observed in the rooms; once removed, staff are to inform administration and educate the resident and family. Record review of Resident #132's clinical records revealed the resident was admitted on [DATE] with diagnosis that included: Chronic Obstructive Pulmonary Disease (COPD) and Atrial fibrillation.Record review of a physician's order sheet revealed Resident#132 had orders dated 4/6/2026 for Albuterol Sulfate HFA Inhalation Aerosol Solution and an order dated 04/07/2026 for Trelegy Ellipta Inhalation Aerosol Powder Breath Activated for COPD.Resident #116Observations on 04/06/2026 at 10:07 AM and on 04/09/2026 at 10:50 AM in Resident #116's room a medicated lotion was on the nightstand. (photo).On 04/09/2026 at 10:51 Staff E, RN made aware of the identified concern and removed lotion.On 04/09/2026 10:52 AM Staff G, CNA was interviewed about facility's protocol for medication storage and stated, I do rounds and if I see any medications I inform the nurse.Record review of Resident # 116's clinical records revealed the resident was admitted on [DATE] with diagnosis that included: Chronic Obstructive Pulmonary Disease and Atrial fibrillation. Record review of Resident # 116's physician's order sheet revealed no orders for medicated lotions. Record review of the facility's policy titled: Clinical-Medication Storage & Labeling. Effective Date: 04/01/2022. Revision Date: 12/9/2025.Policy & Procedures: Clinical-Medication Storage & Labeling.Purpose: To ensure proper storage and labeling of medications within the facility.Process: 1. Medications and biologicals in medication rooms, carts, boxes, and refrigerators are to be maintained within Secured (locked) locations, accessible only to designated staff.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to maintain an accurate medical record for two (Resident #8 and Resident #101) out of two sampled residents. 1) Resident #8 medical record contained documentation that an ordered medication was not administered and facility had documentation that the medication was administered. 2) Resident #101's medical record contained a signed DNR form and care plan. However, upon reentry the signed Advance Directive acknowledgment form indicated Resident #101 expressed wishes to be full code. There were 119 residents residing in the facility at the time of survey. The findings included: Resident # 8On 04/09/2026 at 10:32 AM Resident # 8 was observed receiving left heel wound treatment conducted by the wound care Licensed Practical Nurse (LPN).Record review revealed Resident #8 was admitted on [DATE], clinical diagnosis included but not limited to: Sepsis, Streptococcus, and Bacteremia. Review of the admission Minimum Data Set (MDS) dated [DATE] revealed Resident # 8 had a Brief Interview of Mental Status score of 10, indicating moderate cognitive impairment and was dependent for Activities of Daily Living (ADLs).Review of care plan with initiated 12/05/2025 and revised 12/13/2025 revealed Resident # 8 had sacrum, buttocks and coccyx pressure present upon admission, related to multiple diagnoses and co-morbidities and malnutrition with interventions that included: Encourage resident to accept medications as ordered, encourage resident to accept wound care/dressing changes as ordered, routinely evaluate and document wound status for progress with healing/response to treatments, and notify provider of abnormal findings such as signs and symptoms of infection, increased pain, change in color, and change in temperatureReview of physician orders revealed Resident # 8 had orders dated 3/30/2026 for Levofloxacin Tablet 500 milligrams (mg)1 tablet by mouth one time a day for wound culture infection for 10 Days. Review of nursing notes dated 04/04/2026 revealed Levofloxacin Tablet 500 mg. Give one tablet by mouth one time a day for wound culture infection for 10 Days. Waiting on pharmacy to bring medication. Medication was not administered. Review of nursing notes dated 04/05/2026 documented: Levofloxacin Tablet 500 mg. Give 1 tablet by mouth one time a day for wound culture infection for 10 Days waiting to be receive indicated medication was not administered. Record review of the April electronic Medication Administration Record (EMAR) revealed signatures on 04/01/2026, 04/02/2026, 04/03/2026, 04/06/2026, 04/07/2026 and 04/08/2026 indicating Levofloxacin was administered. On April 4 and 5, 2026 a signature with the code 9 was written indicating Other / See Nurse Notes.On 04/08/2026 at 2:14 PM the Wound Care Licensed Practical Nurse (LPN) reported Resident # 101's wounds are improving.04/08/2026 3:12 PM The Director of Nursing (DON) was made aware of the identified concern and stated, The nurses sign an attestation if anything changes with administration. They do not need to write a progress note. The DON presented surveyor with two documents titled, Attestation of Late entry MAR/TAR indicating Resident # 8 was administered Levofloxacin 500 mg tablet on the 7:00 AM to 3:00 PM shift and the nurse forgot to sign the MAR/TAR, one was signed by Staff and the other by the 1st floor unit manager. The attestations were not found in Resident #8's electronic health record.Interview on 04/08/2026 at 4:06 PM Staff H, Licensed Practical Nurse (LPN) was asked about the concerns with the documentation for 04/05/2026, and stated, I could not find the bingo card for the antibiotic, so I signed 9 in the EMAR, and I explained in the progress note. When I found the antibiotic, I gave it to [Resident # 8], and I forgot to put a progress note. I did sign the Attestation that I administered the medication.On 04/09/2026 at 9:02 AM the DON entered conference room and revealed the physician was called and additional days of antibiotic treatment was ordered for Resident # 8.On 04/09/2026 at 11:42 AM The 1st floor Unit Manager Registered Nurse (RN) stated, I administered Levofloxacin to [Resident # 8] and I did not write a progress note because I completed an attestation and uploaded it to the medical record. On 04/04/2026 the prior nurse was sent home (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and that nurse recorded 9 in the EMAR. I took over the cart and looked for the antibiotic, found it and administered it. I did not write the time it was administered, only the shift. Resident #101On 04/06/2026 at 11:34 AM Resident #101 was observed in bed, no apparent distress noted.Record review of Resident #101's face sheet revealed the residents was admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis that included but not limited to Acute Myeloblastic Leukemia.Record review of a Quarterly Minimum Data Set reference dated 02/10/2026 indicated Resident #101 had moderate cognitive impairment and receiving hospice care.Record review of Resident #101's care plan initiated on 10/09/2025 and revised on: 04/07/2026 revealed Resident # 101 has Advanced Directives wishes in place for Do Not Resuscitate (DNR) and receiving hospice services. Interventions documented included: We will communicate your Advance Directives wishes to pertinent staff and your wishes will be communicated via orders in medical record.Record review of the March 2026 physicians order sheets revealed Resident #101 had an order dated 2/25/2026 for Full Code and an order dated 03/05/2026 for hospice admission with diagnosis of unspecified B-cell lymphoma.Review of an Advanced Directive Acknowledgment form dated 02/25/2026 indicated Resident # 101 choose Full Code.Review of Resident # 101's hospice binder revealed a list of the hospice team with phone numbers, an initial certification dated 02/27/2026 and physician orders.Review of the Electronic Health Record revealed a yellow signed Do Not Resuscitate form dated 9/17/2025 signed by Resident #101. and the physician.Record review a Social Services note dated 02/27/2026 documented Resident # 101's code status is Full Code. The following Advance Directives are in place: none. Resident is oriented. Resident is involved and participates in activities.During an interview on 04/09/2026 at 11:38 AM the Hospice Social Worker stated: We are working on getting [Resident #101] to sign a DNR.During an interview on 04/09/2026 at 3:51 PM Staff I, Licensed Practical Nurse (LPN) revealed Resident # 101's Advanced Directives is Full code.During an interview on 04/09/2026 at 4:22 PM the Director of Nursing (DON) revealed Resident #101 had a DNR that was signed upon initial admission and upon readmission the resident wanted to be Full Code and signed a Full Code Advance Directive. We keep the DNR in the file because it is part of the medical record. [Resident # 101] spoke with the Social Services Director and confirmed wanting a Full Code Advanced Directive.On 04/09/2026 at 4:34 PM the Social Services Director stated, I was not aware [Resident#101] wanted a Full Code Advanced Directive. I do not know who wrote the Social Services note indicating Resident # 101 wanted an Advanced Directive of Full Code and I do not know who wrote it and signed with my electronic signature.During a telephone interview on 04/09/2026 at 5:00 PM the Hospice nurse revealed, Resident # 101 has an Advanced Directive of Full Code. Record review of the facility's Policy and Procedure: Medical Records-Documentation Effective Date 04/01/22Revision Date 11.25.2025 revealed Purpose: To ensure compliance with required medical record documentation per regulatory guidelines for both the paper and electronic medical record (EMR).Procedure:Should an entry be made in error, a line will be drawn through documentation or struck out in the electronic health record

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to collaborate and coordinate with hospice representative for one (Resident #101) out of one sampled resident receiving hospice services as evidenced by: facility staff failed to obtain and keep hospice nursing notes in the hospice folder for Resident #101 since March 2026 when Resident #101 received a physician order for hospice services. There were four residents receiving hospice care residing in the facility at the time of survey. The findings included:On 04/06/2026 at 11:34 AM Resident #101 was observed in bed, call light in reach, no apparent distress and voiced no complaints. Record review of Resident #101's clinical records revealed the resident was admitted on [DATE] and readmitted on [DATE] with diagnosis that included but not limited to: Acute Myeloblastic Leukemia. Record review of a Quarterly minimum data set reference dated 02/10/2026 indicated Resident #101 had moderate cognitive impairment and was receiving hospice care. Record review of a March 2026 physicians order sheet revealed Resident #101 had orders dated 03/5/2026 for Hospice admission Diagnosis: Unspecified B-cell lymphoma. Record review of a care plan initiated 10/09/2025 and revised 04/07/2026 revealed Resident # 101 had Advanced Directives wishes in place for Do Not Resuscitate (DNR) and under hospice interventions that included: We will communicate your Advance Directives wishes to pertinent staff and your wishes will be communicated via order in medical record. On 04/08/2026 at 9:35 AM Resident # 101's [company] hospice binder located at the second-floor nursing station was reviewed and revealed a list of hospice team with number, an initial certification dated 02/27/2026 and physician orders. No nursing notes or sign in sheet were found in the binder. On 04/09/2026 1:35 PM the [company] hospice binder belonging to Resident # 101 located at the second-floor nursing station was reviewed and revealed a list of hospice team with number, an Initial certification dated 2/27/26 and physician orders. No nursing notes or sign in sheets were noted. On 04/08/2026 at 12:56 PM the Hospice admission Registered Nurse was interviewed and stated, I determine eligibility for hospice by examining the resident, reviewing the records, speaking with the medical doctor, and medical staff. The [company] nurse comes weekly and as needed. I communicate with the nursing staff. The notes are usually kept in the binder. I do not know for sure because I do not write the notes. You would have to speak with the assigned hospice nurse.On 04/09/2026 at 3:51 PM Staff I, Licensed Practical Nurse (LPN) was interviewed about hospice visits and how hospice services are coordinated; Staff I, LPN stated: The hospice nurse comes a few times per week. I have never seen the hospice nurse due to the visits occurring in the morning. When the hospice nurse visits the day shift nurse gives me report. Staff I, LPN was asked revealed the notes are to be kept in the hospice binder. The surveyor requested to view the hospice notes; and Staff I, LPN reviewed the hospice binder with the surveyor and stated: The hospice binder contains a list of nurses, demographic sheet, initial certification, representative consent, and medication list. There are no notes in the binder.On 04/09/2026 at 4:05 PM, the Evening Supervisor Registered Nurse was asked where the hospice notes are kept and stated: Notes are kept in the hospice binder. The Evening Supervisor Registered Nurse reviewed the binder and stated, I will ask the Assistant Director of Nursing (ADON).On 04/09/2026 at 4:08 PM the ADON was asked about the facility protocol for coordinating care with hospice nurse and keeping hospice notes; the ADON stated: The hospice nurse reports to the floor nurse and the unit mangers about any new changes. The surveyor inquired if there was any other place that the hospice notes were kept readily available and the ADON revealed hospice notes are kept in the hospice binder. The ADON reviewed Resident # 101's hospice binder and stated: There are no notes for [Resident #101] in the hospice binder. I will have to call the hospice nurse. Indicating notes had not been received by facility since March 2026. Interview on 04/09/2026 at 4:22 PM, the Director of Nursing (DON) stated: The hospice nurse visits a few times week. They don't sign in. The notes are kept in (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the binder. The surveyor informed the DON of the identified concern. During a phone interview on 04/09/2026 at 5:00 PM with the [company] hospice nurse it was revealed I visit weekly and send the notes to medical records.

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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. Based on observations, interview and record review, the facility's Quality Assurance and Performance Improvement Activities (QAPI/QAA) failed to demonstrate an effective plan of action to correct repeated deficiencies in the problem area as evidenced by repeated deficient practices for F761; failed to properly store and label medications during medication administration, F689; failed to prevent accident hazards, F690; failed to ensure a resident with an indwelling urinary catheter received care to prevent infection and F867; QAPI/QAA improvement activities. These repeated deficient practices have the potential to affect the 119 residents residing in the facility at the time of survey. The findings included:Record review of the facility's survey history revealed the facility was cited for F761, F690, F689, and F867 during the recertification and Relicensure survey with an exit date of 09/26/2024. Record review of the facility's Quality Assurance and Performance Improvement (QAPI) Plan revealed revised January 20, 2026 revealed Purpose: The purpose of QAPI in our organization is to take a proactive approach to continually improving the way we care for and engage with our residents, caregivers, and other partners so that we may realize our vision to be a leader in long-term care recognized for excellence, innovation, and outstanding resident outcomes. To do this, employees will participate in ongoing quality assurance and performance improvement efforts which support our mission by striving to care for our residents with compassion, respect, and professionalism. Review of the Quality Assurance and Performance Improvement (QAPI) Committee Meeting Sign-in Sheets dated 01/29/26 revealed the facility had a QAA Committee meeting quarterly and attendees included: Administrator, Medical Director, Director of Nursing (DON) and other department heads. During an interview on 04/09/26 at 4:40 PM with the Administrator/QAA and the Director of Nursing it was revealed, The members of the QAPI team include: the medical doctor, DON, department heads, and the pharmacist. The purpose of QAPI is to discuss continuous quality improvement and review if our Performance Improvement Plans are working by using quantitative data. Surveyor made The Administrator and DON aware of the repeated deficiency concerns that would be cited. The [NAME] stated, We take this as a learning lesson. Record review of the facility's Quality Assurance Performance Improvement Plan Policy Revised January 20, 2026, revealed A facility-wide training will be conducted to inform staff about the QAPI Program. This training will be conducted often and in multiple ways (e.g., in services, department head in services, examples, exercises, etc.). Facility staff will be educated to raise quality concerns, that it is safe to do so, and everyone is encouraged to think about systems.The QAPI approach will also be communicated to consultants, contractors and collaborating agencies, to ensure they recognize their role in the QAPI plan.The facility will ensure residents and families are aware of the QAPI program, and that their views are sought, valued, and considered in facility decision-making and process improvements.