

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105910	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/06/2024
NAME OF PROVIDER OR SUPPLIER Coral Reef Subacute Care Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 9869 SW 152nd Street Miami, FL 33157	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39177</p> <p>Based on observations record reviews and interviews, the facility's staff failed to supervise and implement adequate measures to prevent the elopement for one (Resident #1) out of three residents sampled. The facility's system failure, lack of adequate supervision and a failure in ensuring an adequate alert monitoring system were in place enabled Resident #1 who had risk factors that include visual impairment and seizure disorder, exited the facility undetected on 09/01/2024 shortly after lunchtime. Resident #1 who had displayed and voiced his intent to leave the day prior ambulated 3.2 miles from the facility in areas that has high traffic volume, intersections and cross streets; these factors increased the likelihood of an adverse outcomes, serious injury and serious harm or death. The facility's staff were not aware of Resident #1's absence until the resident's sister called the facility and reported a convenience store owner had called and said her brother was at the store. The Registered Nurse (Staff J) assigned to Resident #1 then left the facility at approximately 5:30 PM in her personal vehicle and picked up Resident #1 at the convenience store. Staff J did not document the incident and failed to inform administration of the incident.</p> <p>Review of the facility's policy titled: Wandering and Elopements Published: 05/19/2023</p> <p>indicated:</p> <p>The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents.</p> <p>Policy Interpretation and Implementation:</p> <ol style="list-style-type: none"> 1. If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety. 2. If an employee observes a resident leaving the premises, he/she should: <ol style="list-style-type: none"> a. attempt to prevent the resident from leaving in a courteous manner. c. instruct another staff member to inform the nurse or director of nursing services that <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>a resident is attempting to leave or has left the premises.</p> <p>3. If a resident is missing, initiate the elopement/missing resident emergency procedure:</p> <p>a. Determine if the resident is out on an authorized leave or pass.</p> <p>b. If the resident is not authorized to leave, initiate a search of the building(s) and premises.</p> <p>and</p> <p>c. If the resident is not located, notify the administrator and the director of nursing services, the resident's legal representative, the attending physician, law enforcement officials, and (as necessary) volunteer agencies (i.e., emergency management, rescue squads, etc.).</p> <p>4. When the resident returns to the facility, the director of nursing services or charge nurse shall:</p> <p>a. examine the resident for injuries.</p> <p>b. contact the attending physician and report findings and conditions of the resident.</p> <p>c. notify the resident's legal representative (sponsor).</p> <p>d. notify search teams that the resident has been located.</p> <p>e. complete and file an incident report; and</p> <p>f. document relevant information in the resident's medical record.</p> <p>Review of the facility's Job duties and essential functions for the Registered Nurses Item 11 indicate: Conducts self in a professional manner in compliance with unit and facility policies.</p> <p>Communication:</p> <p>1. Change of shift report is complete, accurate and concise.</p> <p>2. Incident reports are completed accurately and in a timely manner</p> <p>Review of Resident #1's clinical records revealed the resident was admitted to the facility on [DATE], clinical diagnoses included Chronic obstructive pulmonary disease (COPD), history of transient Ischemic attack (TIA), and cerebral infarction without residual deficits, seizure disorder and visual impairment. Resident #1 was discharged on [DATE].</p> <p>Review of Resident #1's Minimum Data Set (MDS) admission assessment dated [DATE] documented in Section B1200 for Corrective Lenses (contacts, eyeglasses or magnifying glass) used, indicated Yes.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #1's Care Plans initiated 07/13/2024 indicated focus area the resident has highly impaired vision related to the disease process; as per resident only able to follow shadows. The resident is at risk for respiratory distress related to COPD. Has self-care deficit, seizure disorder and hypertensive heart disease.</p> <p>During an interview via telephone on 12/03/2024 at 12:28 PM, Resident #1's sister revealed: On 09/01/2024 at 5:04 PM, I received a call from a woman at a convenience store located at [address]. She told me that she had [Resident # 1] there with her and he had my name, address and phone number on a card that he gave to her. He asked her to call a cab for him. But she called me. instead. I told her that my brother was a patient at Coral Reef, and I would call the facility. When I called the facility they were not aware that my brother was missing. I spoke with the charge nurse and gave the phone number of the convenience store that had called me. Resident # 1's sister revealed the facility staff picked her brother up at the convenience at 5:43 PM and took him back to the facility. She further reported she had sent an email on 09/03/2024 to the Administrator about the incident and received no response.</p> <p>During an interview on 12/04/2024 at 6:33 AM, the Administrator (NHA) revealed she was not aware Resident #1 had left the facility on [DATE]. The NHA reviewed the nursing notes and reported on 08/31/2024 during shift change at around 7:00 PM, Resident #1 was on the patio with his belongings in a bag and would not come inside. The NHA stated: From what I understand from the DON (Director of Nursing) it was the night nurse that encouraged him to come inside. The NHA was asked if she had received an email from the sister, the NHA reported she had not checked her emails.</p> <p>During an interview on 12/04/2024 at 7:11 AM; the DON stated: I checked the weekend 24 hour report and that is when I saw the note, the unit manager said on Saturday he (Resident #1) went outside with his belongings in the yard and the nurse told me she called the family but the patient did not want to come inside and the night shift nurse called the family and the family and she encouraged him to come in; she gave him food and she checked him all night and he did not go back outside anymore.</p> <p>On 12/04/2024 at 11:22 AM during an interview via telephone Staff I stated: I worked on the 3rd cart. I did not know he left the facility he always walked around in the facility. I remember something happened on the patio on August 31st because he went to the patio and the night supervisor, and I convinced him to come back inside. It was in the evening before my shift ended. That was the third time I worked with that patient. I documented that he was upset, and we called the sister.</p> <p>On 12/04/2024 at 11:42 AM the NHA was asked about the facility's video surveillance; the NHA revealed the facility does not have the footage of the resident on the patio because it automatically deletes after a month.</p> <p>On 12/04/2024 at 12:01 PM, during an interview via telephone, Resident #1 revealed he had some difficulty hearing but is able to hear somewhat. The resident was asked how he was able to leave and how he got out of the facility. Resident #1 stated: After I had lunch I walked through the side door and the gate to the sidewalk. The resident revealed he walked far and was a little tired. When asked about the weather that day, Resident #1 stated: It was wet and there were puddles. Resident #1 revealed two nurses picked him up and when he got back to the facility he was taken through the side door, and he had dinner when he returned to the facility.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Education was conducted for 189 out of 200 employees and 11 employees are still pending in-service.</p> <p>Identification of other residents with potential to be affected:</p> <p>All ambulatory residents are likely to be affected by this practice.</p> <p>An evaluation of resident's head count was conducted with 100% residents attendance on 12/5/24</p> <p>An Elopement risk evaluation was conducted on all residents in house on 12/5/24 no new findings noted.</p> <p>Measures / Systematic changes made to ensure non-recurrence:</p> <p>The facility's policy titled Emergency Procedure - Missing Resident was reviewed by the DON and NHA with no changes indicated.</p> <p>The Administrator/DON/Facility Educator/Designee educated facility staff the facility policy titled Emergency Procedure - Missing Resident.</p> <p>The Administrator/DON/Staff Educator/Designee will educate staff on ensuring all incoming and outgoing residents sign in/sign out.</p> <p>Education includes the receptionist who will be responsible for ensuring no one leaves the facility before identification and signing out utilizing the electronic check in system. Nursing staff will monitor residents' attendance and provide adequate supervision to ensure any absence is reported in a timely manner.</p> <p>The education includes staff reporting to the nurse supervisor when resident expresses desire to leave, an elopement evaluation should be conducted.</p> <p>The doors that exit to the enclosed patios are now alarmed. The alarm can only be turned off, when it is manually turned off by a specific code. Based on the location of the doors, a staff member is required to always put in a code in order for the alarm system to be turned off.</p> <p>The residents who tend to wander near the door areas will be redirected by staff.</p> <p>Monthly elopement drills will be conducted on all shifts.</p> <p>Newly hired staff will be educated on elopement and participate in an elopement drill.</p> <p>The daily census will be printed and utilized for obtaining the head count.</p> <p>The Maintenance/Designee will conduct random audit to ensure the facility's gates are locked.</p> <p>The Maintenance/designee will check the gates to ensure they are in working order on a weekly basis and randomly.</p> <p>Monitoring of Corrective Action:</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>39177</p> <p>Based on observations record review and interviews, the facility's staff failed to ensure accuracy of controlled medication and failed to ensure drugs and biologicals used in the facility are stored and disposed in accordance with professional standards; as evidenced by three out of eight medication carts were observed unattended and unlocked, inaccurate narcotic accounting, medications observed in drawers at the north wing nurses' station and medications incorrectly disposed.</p> <p>On 12/02/2024 at 4:55 AM during the initial tour, the west wing's medication cart # 3 assigned to Staff N, RN was observed unlocked and unattended.</p> <p>On 12/02/2024 at 5:04 AM, Staff A, Registered Nurse (RN) observed tossing medications in the trash can attached to the medication cart. Staff A revealed the resident refused the medications, so she had to toss them. Staff A was asked if that was the process to discard medications. Staff A denied tossing the medications in the trash. The medications were retrieved from the trash and Staff A placed them in the sharps container. Staff A did not respond when was asked about the facility's policy for disposing medications.</p> <p>Observation on 12/02/2024 at 5:10 AM with Staff B, RN discontinued medications and the following unused medications: insulin, topical ointments and oral solutions were observed in the drawers at the north wing's nurses' station. Staff B, RN revealed the medications should not be in the drawer and should have been returned to the pharmacy.</p> <p>On 12/02/2024 at 5:15 AM during the north wing's cart #2 narcotics reconciliation review with Staff A, RN; Resident #16 Alprazolam (Xanax) bingo card had 5 tablets remaining and the narcotic disposition log documented by Staff A, RN noted 1 tablet was given on 12/02/2024 at 6:00 AM and 4 tablets remained on hand. Staff A, RN was asked to explain the discrepancies with the time and the amount of tablets left in the bingo card. Staff A, RN, reported the resident had refused the medication and it was an error. Staff A was asked if the resident had requested the as needed, Staff A did not respond.</p> <p>On 12/02/2024 at 5:22 AM narcotic reconciliation review with Staff A, RN for Resident # 17's Lorazepam (Ativan) ordered to be administered every 12 hours as needed, had 14 tablets in the bingo card and Staff A, RN documented on 12/2/02024 1 tablet was given at 9:00 PM and 13 tablets remained on hand. Staff A, RN explained she made an error with the date and had prepared the medications, but the resident had refused the medication. Staff A, RN revealed she usually signed the medications off first and that what she did was incorrect. The supervisor was in the vicinity and acknowledged the concerns.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 12/02/2024 at 7:45 AM, the night supervisor was informed of the concerns related to the medication carts left open, inaccurate narcotic counts, the medications observed in the drawer at the North Wing Nurses station and the nurse tossing pills in trash. The supervisor revealed the carts should not be left open when the nurse is not at the cart. The supervisor had no explanation regarding the medications in the drawer at the nurses station. Regarding discontinued medications, she stated: The regular medications are returned to the pharmacy after they are counted and placed in a gray bag with the label, and kept in the med room to be returned to the pharmacy. On the weekend the discontinued narcotics must be signed by two nurses; we fold the paper put an elastic band around it and put it in a plastic bag at the back of the narcotic box in the cart and on Mondays the unit Manager gives them to the DON. I am not sure because they do it during the week. I don't know how often they do it. The narcotic medications should be signed off immediately after they are removed and if the patient refuses two nurses are required to witness and dispose of the medication.</p> <p>On 12/02/2024 at 5:29 AM the west wing medication cart #1 was observed unlocked and unattended. During a second observation at 5:37 AM, the cart was still unlocked and unattended. The supervisor was shown the unlocked cart and asked which nurse was assigned to the cart. The supervisor revealed Staff D, RN, was assigned to Cart #1. At 5:42 AM Staff D was located. and acknowledged she had left the cart open. During narcotic count conducted with Staff D, the following discrepancies were noted; Resident #25's narcotic disposition log for Lorazepam (Ativan) 5 milligram (5 mg) as needed documented an on-hand amount of 28 but the bingo card had 27 tablets. Resident # 26's Pregabalin 50 mg capsule twice per day (9:00 PM and 9:00 PM) narcotic disposition log documented an on-hand amount of 38, the bingo card had 37 capsules. Resident # 27's Alprazolam (Xanax) as needed narcotic disposition log documented 9 tablets available, but the bingo card had 8 tablets. Staff D acknowledged the discrepancies and revealed the facility's policy is to sign out the narcotic and include the time and amount immediately after the medication is removed.</p> <p>On 12/02/2024 at 6:06 AM, during medication administration and narcotic review for the west wing's cart 2, Staff C, RN left the medication cart unlocked and unattended, entered Resident # 4's room. Staff C, RN reported the cart should not be left unattended and unlocked.</p> <p>On 12/02/2024 at 7:06 AM Staff N, RN was asked about the medication cart observed unattended and unlocked. Staff N revealed: when I am leaving the cart I usually lock it.</p> <p>On 12/04/2024 at 5:50 AM Resident # 15 was observed in bed asleep. At 6:04 AM a narcotic reconciliation for Resident # 15's Oxycodone 5 MG every 6 hours as needed. The bingo card had 2 tablets and the controlled drug disposition log documentation on 06/04/2024 at 6:45 AM Staff E, RN gave 2 tablets to Resident #15. Staff E, RN was asked to explain the discrepancy and explained she had actually given the medication at 5:45 AM not 6:45 AM. Review of the monitoring for the effectiveness of the medication showed no documentation in the Electronic Medication Records (EMAR), The nurse revealed she was not aware of that section in the EMAR. The Unit Manager acknowledge the discrepancy.</p> <p>On 12/02/2024 at 7:00 AM, the Director of Nursing (DON) was informed of the above concerns. When the nurse is giving a narcotic the nurse must check in the computer to make sure the order is right, when the medication is removed the nurse must immediately sign the amount on hand in the book. After the medication is given the nurse should sign the electronic health record; and in 30 minutes document if the medication was effective or not.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility's policy titled Controlled Substances published 09/26 2024 include but not limited to:</p> <p>Dispensing and Reconciling Controlled Substances</p> <ol style="list-style-type: none"> 1. Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up. 2. The system of reconciling the receipt, dispensing and disposition of controlled substances includes the following: <ol style="list-style-type: none"> a. Records of personnel access and usage. b. Medication administration records.

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>39177</p> <p>Based on observations, record review and interview, the facility's staff failed to implement infection prevention control policies and procedures as evidenced by failure to handle soiled linen and garbage to ensure a sanitary environment to help prevent the development and transmission of communicable diseases and infections. This deficient practice has the potential to affect all residents residing in the facility.</p> <p>Observation on 12/02/2024 at 4:55 AM, several clear plastic bags containing trash and soiled linen were observed on the floor in the facility's hallways and resident's doorways.</p> <p>On 12/02/2024 at 4:57 AM during an observation on the east wing Certified Nursing Staff (CNA) Staff H was observed placing soiled linen in a bin and then returned few minutes later to remove clean linen from the clean linen cart that was noted beside two bins (a gray bin and a white bin).</p> <p>On 12/02/2024 at 7:11 AM, Staff H, CNA explained; the soiled linens and garbage should be placed in plastic bags and then in bins in the biohazard room. One bin is for the soiled linen and one for garbage. Staff H stated: Soiled items should never be on the floor in the bag for infection control.</p> <p>On 12/02/2024 at 4:57 AM Staff G, CNA was observed pulling two bags on the floor along the hallways from the west wing to the east wing; one bag had soiled linen, and one bag had trash. Staff G stated: I know the bags should not be on the floor.</p> <p>On 12/02/2024 at 4:58 AM on the west wing Staff S, CNA was observed with bags containing soiled linen and trash on the floor. Staff S exited a resident's room with soiled adult briefs in her gloved hands and placed them in a plastic bag on the floor close to the clean linen cart.</p> <p>On 12/02/2024 at 5:04 AM Staff Q, CNA was observed placing soiled linen and trash in plastic bags at residents' doorways</p> <p>Interview on 12/02/2024 at 7:53 AM, Staff G, CNA revealed she sets up two bags, one for dirty linens and one for the garbage. The bags are knotted and taken to the biohazard room and placed in its specific bin.</p> <p>Review of the facility's policy published 11/24/2024 titled: Laundry and Bedding, Soiled; Policy Statement-</p> <p>Soiled laundry/bedding shall be handled, transported and processed according to best practices for infection prevention and control.</p> <p>Policy Interpretation and Implementation.</p> <p>Handling:</p> <p>1. All used laundry is handled as potentially contaminated using standard precautions (e.g., gloves and gowns when sorting).</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105910	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/06/2024
NAME OF PROVIDER OR SUPPLIER Coral Reef Subacute Care Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 9869 SW 152nd Street Miami, FL 33157	

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)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>a. Contaminated laundry is bagged or contained at the point of collection (i.e., location where it was used).</p> <p>d. Staff handle soiled textiles/linens with minimum agitation to avoid the contamination of air, surfaces, and persons.</p>