STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105939	A. Building B. Wing	02/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palmetto Subacute Care Center	7600 SW 8th Street Miami, FL 33144

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 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 reviewed and interviews, the facility failed to provide oxygen therapy at the rate ordered for one (Resident #104) out of one resident reviewed for respiratory therapy as evidenced by Resident #104 was receiving oxygen at a flow rate of 3.5 liters per minute instead of the physician-ordered 2 liters per minute as needed. This deficient practice has the potential for increased significant health risks including oxygen toxicity and pulmonary damage. The findings include. Observation on 02/02/2026 at 7:38 AM revealed Resident #104 in bed with eyes closed and nasal canula in place with oxygen being administered at a flow rate of 3.5 Liters Per Minute (LPM). Observations of Resident #104 on 02/03/2026 at 11:13 AM and 02/04/2026 at 10:13 AM revealed the resident was seated in a wheelchair with no oxygen in use. Review of Resident #104's clinical record revealed the resident was admitted on [DATE]. Clinical diagnoses included Pneumonitis due to inhalation of food and vomit, with additional respiratory conditions requiring monitoring and treatment. Record review of physician orders dated 01/26/2026 revealed an order for Oxygen at 2 LPM via nasal cannula as needed for shortness of breath or oxygen saturation less than 92%. Review of the admission Minimum Data Set (MDS) dated [DATE], Section O (Special Treatments, Procedures, and Programs), revealed the resident was receiving oxygen therapy. Review of the care plan initiated on 01/24/2026, with a next review date of 04/24/2026, identified the resident as having altered respiratory status/difficulty breathing related to anxiety and pulmonary edema. Interventions included administering oxygen and respiratory treatments as ordered, monitoring oxygen saturation, positioning the resident to promote effective breathing, and monitoring for signs and symptoms of respiratory distress. Interview with Staff F Registered Nurse, on 02/04/2026 at 9:57 AM, revealed the resident orders for PRN (as needed) oxygen at 2 liters via nasal cannula if oxygen saturation is less than 92%, along with prescribed nebulizer treatments. The protocol includes checking vital signs and oxygen saturation before and after respiratory treatments and administering oxygen based on the physician's orders. Interview with Staff G, Registered Nurse Supervisor, on 02/04/2026 at 10:24 AM, revealed nursing staff are expected to review physician orders prior to administering respiratory treatments, complete a respiratory assessment, and administer oxygen and nebulizer treatments strictly according to the physician's prescription. Review of the facility's undated Policy and Procedures titled Oxygen Administration documented:PurposeThe purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation1.Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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, record review and interviews, the facility failed to provide safe and secure storage of medications and biologicals for five Residents (Resident #6, Resident #9, Resident #31, Resident #32 and Resident #102) out of 18 residents sampled. There were 88 residents residing in the facility at the time of the survey. The findings include. During the initial resident and room screenings and subsequent screenings on the 2nd floor North/South Unit of the facility, the following were observed: Resident #6Observation n 02/02/2026 at 7:56 AM revealed Resident #6 in bed awake, a tube of ointment was noted on the overbed table.Observation on 02/02/2026 at 10:36 AM revealed Resident #6 was out of the facility on an appointment and ointment was noted on the overbed table in the resident's room. Review of the medical records revealed Resident #6 was admitted on [DATE]. Clinical diagnoses included but not limited to: Cerebral Infarction due to embolism of left middle cerebral artery. The admission Minimum Data Set (MDS) dated [DATE] revealed: Section C for cognitive patterns documented Brief Interview of Mental Status score is 13 on a 0-15 scale, indicating Resident #6 is cognitively intact. Section GG for functional status documented supervision required for personal hygiene and Activities of Daily Living, impairment on both sides of the lower extremities. Resident #9Observation on 02/02/2026 at 6:42 AM revealed Resident #9 in bed awake, there were several lotions and creams on the bedside table. Observation on 02/03/2026 at 9:19 AM revealed Resident #9 in bed awake watching television. Several lotions and creams noted on the bedside table in a wooden crate.Review of the medical records revealed Resident #9 was initially admitted on [DATE] and readmitted [DATE]. Clinical diagnoses included but not limited to Polyneuropathy, unspecified, Quarterly Minimum Data Set (MDS) dated [DATE] revealed: Section C for cognitive patterns documented Brief Interview of Mental Status score is 13 on a 0-15 scale, indicating Resident #9 is cognitively intact. Section GG for functional status documented dependent for personal hygiene and Activities of Daily Living, impairment on one side of the lower extremities. Resident #31Observation on 02/02/2026 at 6:32 AM, Resident #31 was in bed with eyes closed. A tube of ointment was on the bedside tableReview of the medical records revealed Resident #31 was admitted on [DATE]. Clinical diagnoses included but not limited to Fracture of right patella, subsequent encounter for closed fracture with routine healing. The admission Minimum Data Set (MDS) dated [DATE] revealed: Section C for cognitive patterns documented Brief Interview of Mental Status score is 15 on a 0-15 scale, indicating Resident #31 is cognitively intact. Section GG for functional status documented dependent for personal hygiene and Activities of Daily Living, impairment on one side of the lower extremities. Resident #32Observation on 02/02/2026 at 6:35 AM revealed Resident #32 in bed with eyes closed. A tube of ointment was noted on the overbed table Review of the medical records revealed Resident # 32 was initially admitted on [DATE] and readmitted on [DATE]. Clinical diagnoses included but not limited to: Diverticulosis of large intestine without perforation or abscess with bleeding. The Annual Minimum Data Set (MDS) dated [DATE] revealed: Section C for cognitive patterns documented Brief Interview of Mental Status score is 14 on a 0-15 scale, indicating Resident #32 is cognitively intact. Section GG for functional status documented maximal assistance required for personal hygiene and Activities of Daily Living, impairment on both upper and lower extremities. Resident # 102Observation on 02/02/2026 at 6:46 AM revealed Resident #102 in bed with eyes closed; a tube of ointment and a bingo pack of white round pills were observed at the bedside.Review of the medical records revealed Resident # 102 was admitted on [DATE]. Clinical diagnoses included but not limited to: Cerebral Infarction due to unspecified occlusion or stenosis of right posterior cerebral artery. The admission Minimum Data Set (MDS) dated [DATE] revealed: Section C for cognitive patterns documented Brief Interview of Mental Status score is 15 on a 0-15 scale, indicating (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #102 is cognitively intact.Review of the medical records revealed Resident # 102 was admitted on [DATE]. Clinical diagnoses included but not limited to: Cerebral Infarction due to unspecified occlusion or stenosis of right posterior cerebral artery. admission Minimum Data Set (MDS) dated [DATE] revealed: Section C for cognitive patterns documented Brief Interview of Mental Status score is 15 on a 0-15 scale, indicating Resident #102 is cognitively intact. Interview on 02/03/2026 at 9:48 AM Registered Nurse (Staff A) South Two Unit stated: I do rounds with my residents prior to giving medications (at least 3 times per day) and I am constantly checking on the residents at other times during the day. The residents are long-term residents, several residents are not as alert, and require more frequent check-ins. If the resident has their own lotions, creams and shampoo, they are stored in a [resealable plastic bag] with the room number and are kept in the nightstand drawer. If they have prescribed creams, ointments and lotion, they are kept on the medication cart. Interview on 02/03/2026 at 9:58 AM, Certified Nursing Assistant (Staff B) South One Unit via Spanish Translator revealed the residents' creams and lotions have to be stored in their bedside drawer. Alert residents are allowed to have their own creams and lotions stored in [brand resealable plastic] bags in their bedside drawers. On 02/03/2026 at10:03 AM Registered Nurse (Staff C) South One station, revealed residents' prescribed ointments and creams have to be stored on the medication cart, residents' personal lotions and creams are stored in [resealable plastic bags] in their personal bedside drawer. We have these protocols in place for the safety of the resident. On 02/03/2026 at 10:12 AM, Certified Nursing Assistant (Staff D) North Two Unit via Spanish Translators reported creams, lotions and ointments cannot be stored in the residents' room, if any of those items are found in a resident's room, they have we have been instructed to give the items to the nurse or store in a [resealable plastic bags] in the residents' bedside drawer. On 02/03/2026 at10:23 AM, after Registered Nurse Supervisor (Staff E) was shown the photographs of the surveyor findings in the resident's room; Staff E, Registered Nurse Supervisor revealed Residents' personal creams and lotions are supposed to be stored in a [brand resealable plastic bags] with the room number in the residents' personal drawer. Prescribed cream and ointments are stored on the medication cart. Review of the undated facility policy titled Medication storage states: Medication will be stored in a manner that maintains the integrity of the product and ensures the safety of the residents and is in accordance with Florida

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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 assessment committee failed to demonstrate an effective plan of action was implemented to correct an identified quality deficiency in the problem area related to repeated deficient practice for F761-Label/Store Drugs and Biologicals. As evidenced by: F761 was cited during a Recertification Survey with exit dated 12/19/24 because the facility failed to ensure drugs and biologicals used in the facility were stored and labeled properly. The findings include.Record review of the facility's survey history revealed, during the Recertification Survey conducted on December 16, 2024, through December 19, 2024, F761 was cited as the facility failed to ensure drugs and biologicals used in the facility were stored and labeled properly. Review of the facility policy and procedure titled Quality Assurance and Performance Improvement Plan revision date 09/2025 states: Purpose: Quality is defined as meeting or exceeding the needs, expectations, and requirements of the patients cost-effectively while maintaining good resident/patient outcomes and perceptions of patient care. Quality Assurance Performance Improvement (QAPI) principles will drive decision making within our facility. The purpose of our QAPI plan is to guide our overall quality improvement program. Decisions will be made to promote excellence in promoting quality of care, quality of life, resident choice, person directed care, and resident transitions. Focus areas will include all systems that affect resident and family satisfaction, quality of care and services provided, and all areas that affect the quality of life for persons living and working in our facility. Revisions to the QAPI Plan will be communicated as they occur to residents, families, and staff through meetings, newsletters, etc. With QAPI as our guiding principle, our facility has a Performance Improvement Program which systematically monitors, analyzes, and improves its performance to improve resident/patient outcomes. It recognizes that value in healthcare is the appropriate balance between good measures, excellent care and services and cost. Key issues will be addressed on an ongoing basis to improve overall outcomes. Review of the Quality Assurance and Performance Improvement (QAPI) Committee Meeting Sign-in Sheets dated 11/19/2025, 12/17/2025, and 01/21/2026 documented the facility had QAA Committee meetings monthly. Attendees included: Administrator, Medical Director, Director of Nursing (DON), Assistant Director of Nursing (ADON)Infection Control Preventionist, Risk Manager, Dietary Manager, Clinical Dietician, Director of Housekeeping, Director of Maintenance, Director of therapy, Director of Human resources, Director of admissions, Director of Business office, Director of Social Services, Director of Activities, MDS (Minimum Data Set) Coordinator. Interview on 02/04/2026 at 11:39 AM, the Director of Nursing (DON) reported the QAA Committee meets every month, the last meeting was held on 01/21/2026. The committee consists of the Medical Director, Administrator, Director of Nursing (DON), Infection Preventionist and all interdisciplinary team members. The purpose of QAPI is to identify any potential issues or any concerns, ideally looking at systems and policies that can be improved and continuously evaluating interventions to make sure they are effective. In monthly meetings data from the previous month is reviewed, each department head reports their assigned tasks and any new issues. Data is entered into the QAPI log in the system to be more efficient on topics to be discussed with their recommended interventions for review by the QAPI team.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure appropriate storage of personal cleaning supplies for one Resident (#101) out of 18 sampled residents. As evidenced by dishwashing liquid soap and disinfectant spray stored in the resident's room on a shelf above the handwashing sink. There were 88 residents residing I the facility at the time of the survey. The findings include. On 02/02/2026 starting at 06:30 AM, during the initial resident and room screenings on the 2nd floor North/South Unit of the facility, the following were observed: On 02/22/2026 at 6:38 AM revealed Resident #101 in bed with eyes closed. Cleaning supplies (dishwashing liquid soap, disinfectant spray) were stored in the resident's room on a shelf above the handwashing sink. On 02/03/2026 at 9:20 AM Resident #101 was out of facility on an appointment, the cleaning supplies- (dishwashing liquid soap, disinfectant spray), remained stored in the resident's room on a shelf above the handwashing sink. The Housekeeper was in the resident's room mopping the floor. Review of Resident #101 clinical records revealed the resident was admitted to the facility on [DATE]. Clinical diagnoses included Aftercare Following Joint Replacement Surgery and Unilateral Primary Osteoarthritis, Left Knee. The admission Minimum Data Set (MDS) dated [DATE] revealed: Section C for Cognitive Patterns documented Brief Interview for mental Status Score 15, on a 0-15 scale indicating the resident is cognitively intact. Interview on 02/03/2026 at 9:48 AM with Registered Nurse (Staff A) South Two Unit regarding the cleaning supplies like dishwashing soap and disinfectant sprays being stored in the resident's room. Registered Nurse (Staff A) stated: if I encounter them in the resident's room, I will contact the nursing supervisor to see what to do with the products. While waiting for instructions from the nursing supervisor, I would store the items in a bag on the medication cart.These are long-term residents, several residents are not as alert, and require more frequent check-ins. On 02/03/2026 at 9:58 AM Certified Nursing Assistant (Staff B) South One station, via Spanish Translator revealed cleaning supplies such as dishwashing soap and disinfectant sprays found in the resident's room should be given to the nurse for safe keeping. On 02/03/2026 at 10:03 AM Registered Nurse (Staff C) South 1 station, stated: Any cleaning supplies such as dishwashing soap and disinfectant sprays I find in the residents' room during my rounds are taken out of the room, stored in a bag and the floor supervisor is notified for instructions for storage of the items. The residents are not allowed to have any cleaning supplies in their room. We have these protocols in place for the safety of the resident. On 02/03/2026 at 10:12 AM Certified Nursing assistant (Staff D) North Two Unit via Spanish Translators revealed cleaning supplies such as dishwashing soap and disinfectant sprays found in residents' room should be given to the nurse for safety reasons. On 02/03/2026 at 10:23 AM, after being shown the photographic evidence of the identified concerns; Registered Nurse Supervisor (Staff E) stated: Cleaning supplies are not allowed to be stored in the residents' room. We put all these processes in place to ensure the safety of the residents in our facility. Review of the policy and procedure titled Storage Areas Environmental dated 10/09/25 states: Housekeeping and laundry department storage areas shall be maintained in a clean and safe manner. Cleaning supplies, etc., shall be stored in areas separate from food storage rooms and shall be stored as instructed on labels such as products.