

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106007	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/26/2025
NAME OF PROVIDER OR SUPPLIER Floridean Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 47 NW 32nd Place Miami, FL 33125	
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 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 review facility failed to follow a nutritional care plan for one (Resident #95) out of one sample resident, as evidenced by it was observed that Resident #95 was provided with a ham and cheese sandwich before leaving for dialysis. This meal was not consistent with the prescribed pureed diet, posing potential risks to Resident #95's health and wellbeing. There were 20 residents receiving pureed diets at the time of survey. The findings included: On 9/26/25 at 4:22 AM Resident #95 was observed in bed with no apparent distress. Observation on 9/26/25 at 4:25 AM at the first-floor nursing station revealed a transparent bag labeled with Resident #95's name and room number that contained a ham and cheese sandwich and applesauce (photo evidence). Interview on 9/26/25 at 4:33 AM Staff B, Registered Nurse (RN) was asked about Resident # 95 ?s snack of ham and cheese sandwich and applesauce provided for the resident to take to dialysis; Staff B replied: This resident has been assessed, is waiting for pick up and always goes with a snack of sandwich and applesauce. On 09/26/25 at 4:58 AM, transportation arrived to pick up Resident#95. On 9/26/25 at 5:11 AM, the Assistant Director of Nursing (ADON) and Staff B, RN, were asked if it is okay for Resident #95 to leave with a sandwich despite the ordered pureed diet. The ADON replied: It is okay for the resident [Resident #95] to eat a ham and cheese sandwich because it can be mechanical soft. On 9/26/25 at 5:15 AM Resident #95 had already left the facility with the ham and cheese sandwich and applesauce that was provided. Interview on 9/26/25 at 6:30 AM, the Director of Nursing (DON) was asked if it is okay for Resident #95 who has an ordered pureed diet to be provided with a sandwich to take to dialysis; the DON replied: I will get back to you on that. On 9/26/25 at 6:45 AM, the Dietician was notified about identified diet concern and stated, A sandwich is not considered pureed. [Resident #95] used to be on a regular diet, and I will check with the Speech therapist to see if it is ok to send a sandwich. On 9/26/25 at 6:56 AM, the DON presented a transparent bag with Resident #95's name that contained a ham and cheese sandwich and applesauce and stated: We got the snack from the Dialysis center and replaced it with applesauce. Observation on 9/26/25 at 10:40 AM, Staff C, Speech therapist (ST), conducted a trial feeding of a ham sandwich with Resident #95. After some difficulty in following directions the therapist placed a small piece of bread into Resident #95's mouth and the resident began chewing. The therapist encouraged Resident #95 to swallow . After failing attempts to swallow, the Speech Therapist concluded that it was not safe for Resident #95 to eat sandwiches due to impaired cognition or physical tiredness from dialysis. Record review of a demographic sheet revealed Resident #95 was admitted on [DATE] with diagnosis that included: End Stage Renal Disease. Record review revealed the 5-day Medicare Minimum Data set (MDS) reference dated 9/11/25 revealed Resident #95 had a Brief Interview of Mental Status score of 8, indicating moderate cognitive impairment, required partial/moderate assistance for eating, received a mechanically altered and therapeutic diet, and held food in mouth/cheeks or had residual food in mouth after meals. Record review of a Care Plan initiated on 10/07/23 and revised on 09/08/25 revealed Resident #95 was at risk for altered nutrition and hydration status, had a goal to show no signs or symptoms of dehydration and the interventions included: Provide and serve diet as ordered. (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
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Pureed texture, Nectar Thick consistency, and provide snacks and supplements as ordered. Record review of Resident #95's September 2025 physician's order sheet revealed a diet order for Pureed texture and nectar thick consistency. Record review of a Nutrition/Dietary Note dated 9/10/25 revealed Pureed/Nectar diet. An interview with The Registered Dietician on 9/25/25 at 12:09 PM revealed Resident #95 was on a pureed nectar diet with low sodium and low sugar. Record review of Speech therapy addendum dated 9/15/25 indicated to continue with swallow precautions and compensatory strategies at mealtimes. Record review of a policy titled, Care Plans, Comprehensive Person-Centered revised December 2021, reviewed January 2025 revealed policy statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.		

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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 review facility failed to provide an environment free from potential accident hazards on one (2nd floor storage room) out of nine storage rooms in the facility as evidenced by an unmarked, unlocked storage room with a door that locks from the inside. There were 90 residents residing in the facility at the time of survey. The findings included: Observation of the facility's Second Floor on 9/23/25 at 3:25 PM, an unmarked door; the Surveyor opened the door, which revealed a small room with enteral feeding supplies stacked on shelves. The door could be locked from the inside and there was no call light observed. (photo evidence). On 9/23/25 at 3:30 PM, the Nursing Home Administrator was notified about the identified concern, acknowledged the door was unlocked and locked the door from the inside. Interview on 9/23/25 at 3:40 PM Staff A, Central Supply was asked about the unmarked, unlocked room Staff A stated: This is the storage room, and it is kept locked. Only Maintenance staff, Administration, the Assistant Director of Nursing and myself have a key. When nursing staff needs anything from this room, they tell me, and I retrieve it for them. During an interview on 9/23/2025 at 3:48 PM, the Maintenance Director stated: I am responsible for posting signs on doors in the facility. I am not sure why there is no sign posted. On 9/24/25 at 12:45 PM, the Second Floor Infection Preventionist was interviewed about the identified concern and stated, I am the supervisor; the storage door is kept locked for the safety of our residents because we have residents with Dementia who can wander into the room. Interview on 9/25/25 at 1:36 PM, regarding the identified concerns, the Risk Manager stated: I am part of the Quality Assurance team, and I discuss any issues concerning resident safety. If there is an identified issue with safety, I come up with a plan to prevent it from happening again. The storage door is normally kept locked and labeled. Normally the maintenance staff checks the doors twice a day and the supervisor checks on the weekends. The possibility does exist for a resident to wander into an open storage room and get locked in. Record review revealed the Second-Floor storage room was 28 square feet in dimension. Record review of Policy entitled, Storage Doors effective date: 04/01/2024 review date: 01/03/2025 revealed Policy Statement: All storage room doors containing medical supplies, cleaning agents, maintenance tools, resident records, personal belongings, or hazardous materials must remain closed and locked when not in immediate use. Only authorized personnel shall have access. Procedure: 1. Access Control: All storage areas must be equipped with locks. 2. Door Security: Storage doors must be closed and locked after use. 3. Daily Monitoring: Unit supervisors and department heads must perform daily checks to ensure all storage doors are locked.		

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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. Based on observations, interviews and record review facility failed to properly store and label medications on one (2nd floor east) out of two medication carts sampled as evidenced by an observation of an eye drop bottle with an open date of 8/9/25. There were 90 residents residing in the facility at the time of survey. The findings included: On 9/26/25 at 5:36 AM, a medication storage check was completed with Staff D, Licensed Practical Nurse (LPN) on the 2nd floor east medication cart revealed a Brimonidine eye drop with an open date written on bag of 8/9/25, the dispensed date from pharmacy was 8/8/25. Interview on 9/26/25 at 6:06 AM, Staff D, LPN stated: The eye drops last 28 days after opening. I check every day to make sure there are no expired medications. When I open an eye drop bottle, I write the open date. I did not open this eye drop bottle. On 9/23/25 at 7:01 AM, the Director of Nursing (DON) was notified about the identified concern. Record review of a policy titled, Storage of Medications Revised April 2019, Reviewed January 2025 revealed Policy Statement: The facility stores all drugs and biologicals in a safe, secure, and orderly manner. Class III		

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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. Based on observations, interviews, and record reviews revealed that the facility did not maintain accurate records for one (Resident #99) out of two sampled residents. As evidenced by a review of the September 2025 Medication Administration Record (MAR) showed that staff signed off on all medications as administered, even though no medications were available for Resident #99. There were 90 residents residing in the facility at the time of the survey. The findings included: Observation on 9/23/25 at 12:17 PM while on the second floor, Resident #99 observed standing in the hallway with oxygen in progress via nasal cannula. Resident #99 stated to Staff E, Registered Nurse (RN) I have not received my medication, and it is becoming difficult to breathe.&rdquo; Staff E, RN replied, &ldquo;The medication has not arrived from the pharmacy yet.&rdquo; Resident #99 then went back into room. Surveyor asked Staff E, RN which medications were missing and if an assessment would be completed and Staff E, RN replied, &ldquo;Resident #99 vitals were within a normal range, and the medications were ordered last night.&rdquo; Interview on 9/23/25 at 12:25 PM, Resident #99 stated: &ldquo;I can breathe but had been waiting on the medication, and I will have difficulty breathing if I don't get it. I was admitted last night.&rdquo; Record review of the September Medication Administration Record (MAR) for Resident #99 revealed all medications were signed administered at 9:00 AM for the date 9/23/25. On 9/23/25 at 4:40 PM, the Director of Nursing entered the conference room and revealed all medications for Resident #99 had arrived and the physician was notified and stated it was okay to give meds upon arrival. Further revealed Staff E, RN signed the MAR due to being nervous. On 9/23/25 at 4:51 PM Staff E, RN (translated by another surveyor) was interviewed about identified concern and stated, &ldquo;I sign the MAR after I give the medication. There is not a time I would sign before. If the medication is not here, I mark no and write in the progress notes and call the doctor and pharmacy. I did not give [Resident #99] any medication this morning because it was not here. I signed The MAR as administered in error.&rdquo; Record review of Resident #99's demographic sheet revealed an admission date of 9/22/25 with Diagnosis that included: Acute and chronic respiratory failure with hypercapnia. Record review revealed the admission Minimum Data set (MDS) reference dated 9/22/25 was in progress. Record review of a Care Plan initiated and revised on 09/23/2025 revealed Resident #99 was at risk for altered respiratory status/difficulty breathing related to: Asthma, Chronic Obstructive Pulmonary Disease (COPD), Pneumonia, Acute on Chronic Respiratory Failure, Alkalosis, Hypo-osmolality and Hyponatremia, Hypoxemia, had a goal to maintain normal breathing pattern as evidenced by normal respirations, normal skin color, and regular respiratory rate/pattern through the review date and interventions that included: Administer medication/inhalers/nebulizers as ordered and monitor Oxygen saturations as ordered and as needed, and teach resident/family/caregivers appropriate breathing, coughing, and splinting techniques. Record review of Resident #99's September 2025 physician's order sheet revealed orders included: (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Budesonide-Formoterol Fumarate Inhalation Aerosol 160-4.5 microgram per actuation (MCG/ACT) two puffs every 12 hours related to Acute and chronic respiratory failure with hypercapnia, Ipratropium Bromide Nasal Solution 0.03 % two sprays in both nostrils one time a day for Bronchodilator, Acclidinium Bromide Inhalation Aerosol Powder Breath Activated 400 MCG/ACT one inhalation two times a day for Bronchodilator related to COPD with Acute Exacerbation, and Fluticasone Propionate Nasal Suspension 50 MCG/ACT two sprays in both nostrils one time a day for Congestion, Azelastine hydrochloric acid (HCl) Nasal Solution 137 MCG per spray directions: 1 spray in both nostrils every six hours for congestion, Prednisone oral tablet 20 milligrams (MG) tablet by mouth one time a day for COPD exacerbation, and Montelukast Sodium Oral Tablet 10 MG tablet by mouth in the evening for Bronchodilator related to COPD. Record review of a pharmacy packing slip revealed medications for Resident #99 were delivered to facility and signed received by Supervisor on 9/23/25 at 2:43 PM. Record review of a policy titled, Charting Errors and/or Omissions/Accuracy of Medical Records revised January 2025 revealed Policy Statement: Accurate medical records shall be maintained by this facility.		