STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106031	A. Building B. Wing	08/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Victoria Nursing & Rehabilitation Center, Inc.	955 NW 3rd St Miami, FL 33128

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 observation, record review and interview, the facility failed to implement a fall care plan for one (Resident #7) out of one sampled resident at risk for falls as evidenced by Resident # 7 was left unattended/unsupervised lying in a high positioned bed. This deficient practice increases the resident's risk of falling and potentially sustaining severe life-threatening injuries. The findings included:During the facility tour on 8/4/25 at 8:43 AM, on the facility's 3rd floor northbound hallway Resident #7 was observed lying in a bed that was in a high position, one floor mat was observed on the left side of the bed and no staff was present in the room. The surveyor immediately notified Staff A, Certified Nursing Assistant, who was gathering linens from the cart on the opposite side of the hallway. Staff A, Certified Nursing Assistant, immediately went to the room and lowered the bed. When asked why Resident #7 was left unattended in the high positioned bed, Staff A stated: I was getting the linen.Record review of Resident #7's demographic face sheet revealed the resident an initial admission date of 5/24/21 and was readmitted on [DATE] with diagnosis that included: History of falling.Record review of a Medicare 5-day Minimum Data Set, dated [DATE] section for cognitive status indicated Resident # 7 has moderate cognitive impairment; the section for functional status revealed the resident is dependent on Activity of Daily Living (ADLs) and the Health Conditions section revealed Resident #7 had a fall in the last 2-6 months prior to admission/entry or reentry.Record review of a Care Plan initiated on 06/14/2024 and revised on 06/16/2025 revealed Resident #7 was at risk for falls with interventions that included: Bed to be in the lowest setting always as ordered.Record review of a nursing note dated 02/20/2025 revealed Resident #7 had a fall.On 8/4/25 at 12:57 PM Staff A, Certified Nursing Assistant revealed: When I am providing care, I remove one floor mat and put the bed up for proper body mechanics. While I was waiting for someone to help me transfer [Resident#7], I went to the linen cart outside of the room and left the bed up and only one floor mat because she was sleeping.On 8/4/25 at 2:27 PM, the Risk Manager revealed Residents are closely monitored by the resident upon admission to determine risk for falls. If a resident is at risk, bilateral floor mats are placed and an identification band. Staff remove the floor mats to provide care. The resident is to be supervised if a floor mat is removed. The bed is also to remain low if resident is unsupervised.Review of the facility policy and procedure titled Safety and Supervision of Residents Revised January 2025 revealed Policy Statement: Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities.Policy Interpretation and Implementation: Individualized, Resident-Centered Approach to Safety:4. Implementing interventions to reduce accident risks and hazards shall include the following:d. Ensuring that interventions are implemented.

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to provide an environment that is free from potential accidents and hazards for one (Resident #7) out of three sampled residents, as evidenced by Resident # 7 who is at risk for falls was observed in high positioned bed unattended/unsupervised. This deficient practice increases the resident's risk of falling and potentially sustaining severe life-threatening injuries. There were 51 residents residing on the third floor at the time of survey. The ndings included:Observational tour of the facility's third floor on 8/4/25 at 8:43 AM, revealed Resident #7 lying in a high positioned bed, one oor mat was on the left side of the bed and no staff was present in the room. The surveyor immediately noti ed Staff A, Certi ed Nursing Assistant, who was gathering linens from the cart on the opposite side of the hallway. Staff A, Certi ed Nursing Assistant, immediately went to the room and lowered the bed. When asked why Resident #7 was left unattended in the high positioned bed, Staff A stated: I was getting the linen.Record review of Resident #7's demographic face sheet revealed the resident an initial admission date of 5/24/21 and was readmitted on [DATE] with diagnosis that included: History of Falling.Record review of the physician's order sheet revealed an order dated 6/15/25 for bilateral oor mats while resident in bed every shift for fall precaution.Record review of a Medicare 5-day Minimum Data Set, dated [DATE] section for cognitive status indicated Resident # 7 has moderate cognitive impairment; the section for functional status revealed the resident is dependent on Activity of Daily Living (ADLs) and the Health Conditions section revealed Resident #7 had a fall in the last 2-6 months prior to admission/entry or reentry. Record review of a Care Plan initiated on 06/14/2024 and revised on 06/16/2025 revealed Resident #7 was at risk for falls with interventions that included: Bed to be in the lowest setting always as ordered. Record review of a nursing note dated 02/20/2025 revealed Resident #7 had a fall.On 8/4/25 at 12:57 PM Staff A, Certi ed Nursing Assistant stated, [Resident #7] has an order for two oors mats one on each side. When I am providing care, I remove one oor mat and put the bed up for proper body mechanics. While I was waiting for someone to help me transfer [Resident #7], I went to the linen cart outside of the room and left the bed up and only one oor mat because she was sleeping.On 8/4/25 at 2:27 PM, the Risk Manager revealed Residents are closely monitored by the resident upon admission to determine risk for falls. If a resident is at risk, bilateral oor mats are placed and an identi cation band. Staff remove the oor mats to provide care. The resident is to be supervised if a oor mat is removed. The bed is also to remain low if resident is unsupervised.Review of the facility policy and procedure titled Safety and Supervision of Residents Revised January 2025 revealed Policy Statement: Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities.Policy Interpretation and Implementation:Individualized, Resident-Centered Approach to Safety:4. Implementing interventions to reduce accident risks and hazards shall include the following:d. Ensuring that interventions are implemented.