

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

Printed: 03/01/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106031	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/12/2024
NAME OF PROVIDER OR SUPPLIER Victoria Nursing & Rehabilitation Center, Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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** 48906 Based on observations, interviews, and record review, the facility failed to provide privacy on one out of eight medication cart computer screens and failed to provide privacy during medication administration as evidence by resident's information visible on the unattended open sixth floor's west cart computer screen and staff failed to provide privacy during medication administration for Resident #57. The findings included: Observation on 12/10/24 at 9:23 AM, revealed resident's information visible on the unattended sixth floor's west medication cart. (photo) On 12/10/24 at approximately 9:30 AM, Staff A, Licensed Practical Nurse (LPN) stated: The protocol is to lock the computer screen by pressing the lock icon when I am away from the cart to protect residents' information. I left it open because I was called for an emergency situation. On 12/11/24 at 8:38 AM, during a medication administration observation with Staff C, Registered Nurse (RN) on the second-floor's medication cart for Resident #1. Staff C, RN entered the resident's room and did not close the door and administered the medications without pulling the curtain to provide privacy. Interview on 12/11/24 at 4:05 PM, Staff C, RN was asked to explain the facility's privacy protocol during medication administration. Staff C, RN stated: When I administer medications to a resident who lives in a double occupied room, I close the door. [Resident #57] was in the room by herself and that is why I didn't pull the curtain or close the door. The way the Resident #57 was seated, there was privacy. Staff C, RN went with surveyor and stood at the nursing station located directly before Resident#57's room. Staff C, RN acknowledged the Resident#57 was fully visible while the door was opened and the curtain not pulled, therefore privacy was not provided. Interview on 12/12/24 at 1:43 PM, the Director of Nursing (DON) revealed, the nurses are to lock the computer screens when they walk away from the screen and pull the curtain and close the door during medication administration if the room is double occupied. (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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's title; Policy Confidentiality of Information and Personal Privacy revised January 2024 revealed: Policy Statement: [NAME] Nursing and Rehabilitation Center will protect and safeguard resident confidentiality and personal privacy. Policy Interpretation and Implementation: [NAME] Nursing and Rehabilitation Center will safeguard the personal privacy and confidentiality of all resident personal and medical records. [NAME] Nursing and Rehabilitation Center will strive to protect the resident's privacy regarding his or her: medical treatment; Access to resident personal and medical records will be limited to authorized staff and business associates. Review of a Policy titled, Privacy of Residents revealed Policy Statement: revised January 2024 Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, feeling of self-worth and self-esteem. Policy Interpretation and Implementation 10. Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48906 Based on record review and interview the facility failed to ensure an accurate Level I Preadmission Screening and Resident Review (PASRR) was completed in a timely manner for two residents (Resident #254 and Resident #266) out of 12 residents sampled as evidenced by a Level I PASRR dated 7/24/24 for Resident #254 omitted diagnosis of Generalized Anxiety Disorder and Level I PASRR dated 10/9/24 for Resident#266 omitted diagnosis of Major Depressive Disorder. There were 307 residents residing in the facility at the time of survey. The findings included: (1) On 12/09/24 at 1:09 PM Resident #254 was observed seated in bed, a tracheostomy in place and communicated with hand gestures. Record review of Level I PASRR for Resident#254 revealed Screen and Determination Admitting diagnosis: Paralysis Agitation others: Altered Mental status: PASRR: Section I: Guide for Determining an indication of, or a Diagnosis of, a serious mental illness (MI), Mental Retardation (MR) or Related Condition: check those that apply: Depressive Disorder and Psychotic Disorder were checked. Section II: Part A: Mental Illness: No Part B- Mental Retardation: No. Signed by employee on 7/24/24. Record review of Resident #254's clinical records revealed an initial admitted [DATE] and re-entry date of 7/25/24 with diagnosis that include: Anxiety, Major Depressive disorder, and Psychosis. Review of a quarterly MDS reference dated 9/21/24 Section I indicate Resident#254 had Psychiatric/Mood Disorder of Anxiety, Depression, and Psychotic disorder. Section N (medications) revealed Resident #254 was taking Antipsychotic, Antianxiety and Antidepressant medication during the last seven (7) days. Review of Care Plan with start date 7/6/24 and revised on 7/6/24 revealed Resident #254 has a behavior problem of anxiousness and paranoid thoughts related to Anxiety, Psychosis with a goal to have fewer episodes of (anxiousness and paranoid thoughts and behavior). Review of a physician orders sheet dated 7/24/24 revealed an order for Buspirone Oral Tablet 5 Milligram (MG) directions: Give one tablet two times a day related to Generalized Anxiety Disorder. Record review of a Psychiatric Note dated 11/20/24 revealed diagnosis included General Anxiety disorder. (2) On 12/10/24 at 9:44 AM An observation was made of Resident #266 in bed, awake, alert responding verbally. (continued on next page)		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Level I PASRR for Resident #266 revealed Screen and Determination Admitting diagnosis: Paralysis Agitation others: Altered Mental status: PASRR: Section I: Guide for Determining an indication of, or a Diagnosis of, a serious mental illness (MI), Mental Retardation (MR) or Related Condition: check those that apply: Anxiety and Psychotic Disorder were checked. Section II: Part A: Mental Illness: No Part B- Mental Retardation: No. Signed by employee on 10/9/24. Review of Resident #266's demographic sheet revealed an initial admitted [DATE] with diagnosis that included: Anxiety, Major Depressive disorder, and Psychosis. Record review revealed a Modification of Admission MDS with a reference date of 10/13/24 Section A (Identification) revealed the resident is not currently considered by the state Level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. Section I Resident#266 had Psychiatric/Mood Disorder of Anxiety, Depression, and Psychotic disorder. Section N (medications) revealed Resident#254 was taking Antipsychotic and Antidepressant medication during the last seven (7) days. Review of Resident #266's Care Plan with a start date of 12/10/24 revealed the resident had a sad mood problem related to Depression with a goal to improve mood state (happier, calmer appearance, no signs and symptoms of Depression, Anxiety or sadness) through 1/07/25. The interventions included: Administer medications as ordered, monitor/document for side effects and effectiveness and behavioral health consults as needed (psycho-geriatric team, psychiatrist) Review of a Psychiatric Note dated 11/20/24 revealed Resident #266 had Major Depressive Disorder. Review of a physician orders sheet revealed an order dated 11/15/24 for Sertraline Oral Tablet 100 MG directions: Give one tablet one time a day related to Major Depressive Disorder. On 12/11/24 at 3:16 PM an interview was held with Staff J, Advanced Practice Registered Nurse (APRN) and The Director of Social Services. The Director of SS stated, Upon admission I review the psychotropic medications from the hospital and compared them to the PASSR received from the hospital to ensure the diagnosis are accurate or if a new PASSR need to be completed and I passed on that information to the APRN. If no new PASSR is needed, the facility accepts the PASSR from the hospital and if a new one is needed the PASSR is redone upon admission and readmission. When there is a significant change in behaviors while in facility, we consider a resident review. The Social Services Director revealed: The diagnosis of Anxiety was not included for [Resident #254] due to my error because The PASSR from the hospital was blank and because I thought the medications were only being used for Depression. I then gave that information to the APRN, and he signed it off. The diagnosis of Depression was not included on [Resident#266's] PASSR because there was no active medication at the time of admission and no significant behavioral change pertaining to the PASSR. Staff J, APRN stated, I work with the Social Services director to check if the diagnosis are accurate and if a new PASSR is needed. I double checked the PASSR for Resident#254 and Resident#266 and I didn't realize Anxiety and Depression were omitted. (continued on next page)		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a Policy titled, Pre-Admission Screening and Resident Review (PASRR) Revised January 2022, Reviewed January 2023, January 2024 revealed Policy Statement: Our facility admits only residents who's medical and nursing care needs can be met. Policy Interpretation and Implementation 1. All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-Admission Screening and Resident Review (PASRR) process. (2) The social worker or designee is responsible for making referrals to the appropriate state-designated authority.		

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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** 48906 Based on observation, interview and record review the facility failed to administer oxygen as ordered for one Resident (#244) out of twelve sampled residents as evidenced by Resident #244 was observed without nasal cannula in place resulting in decreased oxygen saturation level. The findings included: On 12/09/24 at 4:40 PM Resident#244 was observed lying in bed; an oxygen concentrator in progress at 2 L/min (2 liters per minute) and the nasal cannula that was not in a bag noted on top of the concentrator. (photo) Observation and interview on 12/09/24 at 4:51 PM; Staff B, Registered Nurse (RN) revealed Resident #244 is currently prescribed oxygen at a rate of 2 Liters per minute (L/M) continuously. Resident # 244's oxygen saturation level was measured, and the oxygen saturation level result was 86%. Staff B, RN rechecked the saturation level and the same result was noted. Staff B, RN applied the nasal cannula and measured the oxygen level, and the result was 94%. When asked what the resident's normal saturation levels was and if 86% was normal, Staff B, RN revealed 86% is low. When asked why the nasal cannula that was not in place Staff B, RN stated: When the Certified Nursing Assistant (CNA) transferred [Resident#244] from the recliner to the bed it was removed, and I was not notified. I monitor Residents by rounding every hour to make sure oxygen interventions are in place. I communicate with CNAs verbally at the beginning of the shift about needed interventions. Record review of a demographic sheet for Resident#244 revealed an admitted [DATE] with diagnosis that included: Hypertensive Heart and Chronic Kidney Disease with Heart Failure. Record review of a physician's order sheet revealed orders dated 12/1/24 directions: Oxygen Via Nasal Cannula at 2 L/min every shift for Shortness of Breath (SOB) and 10/23/24-Oxygen saturation spot check every day shift and as needed (PRN). Record review of a Care Plan initiated on 10/27/2024 and revised on 11/05/2024 revealed Resident # 244 had Oxygen Via Nasal Cannula at 2 L/min PRN for SOB with a goal to display optimal breathing patterns daily through 1/27/25. The interventions included: Oxygen Via Nasal Cannula at 2 L/min PRN, monitor oxygen saturation as ordered, and observe skin color for development of cyanosis. Record review of the December 2024 Medication Administration Record for Resident#244 revealed licensed nursing staff signed each day for day and night shift the order: Oxygen via nasal cannula at 2 L/min every shift for SOB. On 12/11/24 at 12:55 PM Staff I, RN was asked about the order for Resident #244's oxygen. Staff I, RN replied, I am the nurse for this resident yesterday and today. The order is for oxygen continuous at 2 Liters per minute continuously. I do rounds to make sure the oxygen is at the rate and the nasal cannula is in place. I communicate with the CNAs by telling them the oxygen is for continuous, and they are not to remove the nasal cannula. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/11/24 at 01:07 PM, Staff J, CNA was asked what the protocol for Resident #244 while receiving oxygen, Staff J stated: I am the CNA for this resident in the morning. This resident has continuous oxygen because the nurse explained that to me. I never removed the nasal cannula from the resident. I have seen the resident remove the nasal cannula and I replace it and let the nurse know. On 12/12/24 at 1:38 PM, the Director of Nursing (DON) stated: There should be a doctors order for the rate and the nurse should be monitoring if the resident is receiving the accurate liters and receiving the oxygen. The CNAs are always in contact with the resident and if they see the oxygen is not in place they inform the nurse. If the resident is restless and moving a lot that might be an instance of the nasal cannula not being in place. The nurse should also measure the oxygen saturation on room air and with oxygen in progress. The nurse should follow up by notifying the doctor. Record review of a Policy titled; Oxygen Administration Reviewed January 2024 revealed Purpose: The purpose of this procedure is to provide guidelines for safe oxygen administration. 1. Oxygen therapy is administered by way of an oxygen mask, nasal cannula, and/or nasal catheter.		

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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** 48906 Based on observations, interviews and record review the facility failed to properly store medication for four residents (Resident #254, Resident #6, Resident #21, and Resident #163) out of eight sampled residents; as evidenced by observations of a nasal spray at the bedside of Resident#254, sore throat medicine at Resident#6's bedside, Ammonium lactate and Ketoconazole shampoo on Resident#21' nightstand, eye drop and nasal spray at Resident#163's bedside There were 307 residents residing in the facility at the time of survey. The findings included: On 12/09/24 at 1:09 PM a bottle of nasal spray was observed at Resident#254's bedside. On 12/09/24 at 05:34 PM Staff G, Registered Nurse (RN) was asked if residents are allowed to keep nasal sprays at their bedside and Staff G, RN replied, No. Staff G, RN then entered Resident #254's room and removed the nasal spray and educated Resident #254. On 12/09/24 at 8:48 AM a sore throat medicine was observed at Resident#6's Bedside. Observation and interview on 12/09/24 at 5:37 PM the Respiratory Director revealed: I saw the sore throat spray at the bedside and gave it to the nurse. On 12/09/24 at 4:04 PM Ammonium lactate and Ketoconazole shampoo was observed on the Resident#21's nightstand. (Photo) On 12/09/24 at 5:40 PM, Staff E, RN was informed of the medication at Resident # 21's nightstand. On 12/09/24 at 5:09 PM- eye drop and nasal spray observed at Resident #163's. On 12/09/24 at 5:45 PM Staff B, RN was asked if Resident#163 was allowed to have the eye drop and nasal spray at bedside. Staff B, RN replied, I am not sure I will check with the supervisor. On 12/09/24 at 5:42 PM Staff D, Assistant Director of Nursing (ADON) was asked if any eye drops, nasal sprays, lotions or shampoos can be kept at the bedside of residents'. The ADON replied. No and we will take care of that. On 12/12/24 at 1:43 PM The Director of Nursing revealed: Medicated lotions, nasal sprays and eye drops are not to be at bedside. The family members often bring eye drops and nasal sprays for the residents. We educate the family to not bring any medications. We have guardian angels and staff that are constantly checking the resident rooms for medications and if so to remove them. (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a Policy, titled Storage of Medications revised January 2024 revealed Policy Statement: [NAME] Nursing and Rehabilitation Center stores all drugs and biologicals in a safe, secure, and orderly manner. Policy Interpretation and Implementation: Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls, Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed and only persons authorized to prepare and administer medications have access to locked medications.		