STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106034	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jackson Gardens Health and Rehabilitation Center	1861 NW 8th Avenue Miami, FL 33136

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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 - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations, interviews and records reviewed, the facility failed to maintain an environment free of accident hazards in two (fourth floor and second floor) out of three air conditioning unit rooms which could be locked from the inside and were found unlocked, presenting a risk that residents might enter and become trapped. There were 111 residents residing in the facility at the time of survey. The findings included: On 05/04/2026 during an observational tour conducted at 11:10 AM on the fourth floor and at 11:32 AM on the second floor the Air Conditioning (AC) unit room doors were found unlocked, further inspection of the doors revealed the doors were lockable from the inside. (Photographic evidence). No staff members were observed near to these rooms. Record review of the facility's policy and procedure titled, Safety Precautions, General revised January 2022; Policy Statement indicated: All personnel shall follow general safety precautions established by this facility. Policy Interpretation and Implementation: The following general safety precautions have been developed for all personnel to follow. We expect you to follow these precautions, as well as other precautions that may become necessary and appropriate. 1. Follow established safety precautions as well as those that may become necessary or appropriate. On 05/04/2026 at 11:45 AM the Maintenance Director revealed the AC unit rooms are considered mechanical rooms and should be kept locked and only maintenance personnel retain the key. On 05/04/2026 at 12:00 PM the Corporate Maintenance staff stated: Maintenance staff left the AC rooms open for the housekeeping to clean the room. The doors are to be locked.

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, records reviewed and interviews, the facility did not store medications and biologics correctly on two out of three medication carts (fourth floor carts 1 and 2) and in one out of two medication rooms (second floor medication room) selected for checking medication labeling and storage. Expired, unlabeled, and mislabeled eye drops and insulins were found in fourth floor medication carts 1 and 2. The refrigerator in the second-floor medication room was above the recommended temperature for storing medications. At the time of the survey, the facility had six medication carts and three medication rooms. The findings included: On 05/04/2026 at 9:04 AM medication storage and labeling check completed with Staff F, Registered Nurse (RN) on the fourth-floor medication cart 2 revealed: 1.A box of Ketorolac Tromethamine 0.5% ophthalmic solution labeled for Resident # 27 had an additional label for Resident # 4. The bottle was open and had no open date on the bottle nor box .(Photo evidence). 2.A bottle of Timolol Maleate 0.5% ophthalmic solution for Resident # 32 was open, and no open date was written on bottle nor box. (Photo evidence). 3. A bottle of Moxifloxacin 0.5% ophthalmic solution was open, and no open date written on bottle nor bag for Resident # 27. (photo evidence). 4. A Novolog flex pen 100 unit per (/) milliliter (ml) for Resident # 81 had an open date written of 3/18/26 and expiration date of 4/15/26 and a label with instructions to throw away any medicine that remains 28 days after first use. 5. A Novolog Pen Solution 100 unit/ml for Resident # 4 had an open date written on 3/31/26 and expiration date of 4/28/26 and a label with instructions to throw away any medicine that remains 28 days after first use. 6. Two Lantus injector flex pens for Resident # 86 had an open date of 3/31/26 and expiration date of 4/28/26 (photo evidence). 7. A Novolog injector flex pen for Resident # 81 was open and had no open date written on bag or pen. (Photo evidence). 8. A Lantus injector flex pen for Resident # 17 had an open date written of 4/2/26 and expiration date of 4/26/26. (Photo evidence). 9. A NovoLog injection flex pen for Resident # 17 was open, and no open date was written on pen or bag. (Photo evidence). 10. One oval shaped, white loose pill was observed in the medication cart. On 05/04/2026 9:15 AM a medication storage and labeling check completed with Staff G, RN on the (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	fourth-floor medication cart 1 revealed: 11. An open bottle of a Latanoprost ophthalmic solution 0.005% for Resident # 60 had no open date written on bottle or bag. (Photo evidence). 12. A Brimonidine ophthalmic solution 0.2% for Resident # 53 was open, and no open date was written on bottle or bag. (Photo evidence). Resident # 27 Record review of the clinical record revealed Resident # 27 was admitted on [DATE] and had physician orders dated 4/30/26 for Ketorolac Tromethamine Ophthalmic Solution 0.5 %, Instill 1 drop in left eye four times a day for Cataract post-Surgery and Moxifloxacin HCl Ophthalmic Solution 0.5 %, Instill 1 drop in left eye four times a day for Cataract. Resident # 32 Record review of the clinical record revealed Resident # 32 was admitted on [DATE] and had a physician order dated 12/13/2024 for Timolol maleate solution 0.5%, Instill 1 drop in both eyes two times a day related to Primary open angle glaucoma. Resident # 81 Record review of the clinical record revealed Resident # 81 was admitted on [DATE] and had a physician orders dated 9/5/25 for Insulin Aspart Flex pen 100 UNIT/ML Solution pen-injector Inject subcutaneously before meals for Diabetes Mellitus. Resident # 4 Record review of the clinical record revealed Resident # 4 was admitted on [DATE] and had a physician order dated 3/10/26 for NovoLog Flex Pen 100 UNIT/ML Solution pen-injector Inject subcutaneously before meals and at bedtime for Diabetes Mellitus (DM). Resident # 86 Record review of the clinical record revealed Resident # 86 was admitted on [DATE] and had a physician order dated 09/02/2025 for Lantus Solostar 100 UNIT/ML Solution pen-injector Inject 10 unit subcutaneously one time a day for Diabetes Mellitus. Resident # 17 Record review of the clinical record revealed Resident # 17 was admitted on [DATE] and had physician orders dated 08/31/2025 for Insulin Aspart Flex Pen 100 UNIT/ML Solution pen-injector, inject subcutaneously before meals and at bedtime for Diabetes Mellitus and an order dated 11/20/25 for Lantus Solostar 100 UNIT/ML Solution pen-injector, Inject 18 unit subcutaneously at bedtime for Diabetes Mellitus. Resident # 60 (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the clinical record revealed Resident # 60 was admitted on [DATE] and had physician orders dated 08/11/2025 for Latanoprost Solution 0.005 % Instill 1 drop in both eyes at bedtime for Glaucoma. Resident # 53 Record review of the clinical record revealed Resident # 53 was admitted on [DATE] and had a physician order dated 03/05/2026 for Brimonidine Tartrate Ophthalmic Solution 0.2 , Instill 1 drop in both eyes two times a day for ocular hypertension Bilateral Eyes. Review of a pharmacy medication storage list indicated Novolog and Lantus insulins have a beyond use date of 28 days after first use and Timolol eye drops manufacturer expiration date of 28 days after opening. Review of the facility's policy titled, Storage of Medications revised January 2026 revealed Policy Statement: The facility stores all drugs and biologicals in a safe, secure, and orderly manner. Policy Interpretation and Implementation: 4. Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy or destroyed. 5. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed. During an Interview on 05/04/2026 at 1:00 PM the Consultant Pharmacist stated: I review the medications and complete onsite audit visits. I check to make sure the multi dose medications are dated after open and everything is per regulation. All multidose medications need to be dated after opening because after opening they need to be disposed of by a certain date or they can become chemically unstable. An insulin pen injector can generally be kept opened on the medication cart for 28 days. On 05/04/2026 at 3:09 PM Staff F, RN stated: I put insulins from the pharmacy into the refrigerator. When I open the insulin, I write an open date and expiration date. For the eye drops I write an open date and an expiration date. I throw away any expired medications. The surveyor asked if two residents names can be labeled on the same medication and the staff stated: No. The surveyor asked if the open date is not written how does staff determine when medication expires and Staff F, RN did not reply. On 05/04/2026 at 3:11 PM Staff G, RN stated, When insulins are opened an expiration date of 28 days later is written and expired ones thrown away and the same for eye drops. For the liquid Lorazepam I received it from the pharmacy and placed it in the cart, but it should have been placed in the fridge. The surveyor asked if the open date is not written on medication how does staff determine when the medication expires and Staff G, RN replied, I use the pharmacy dispensed date. During an interview on 05/07/2026 at 2:35 PM the Director of nursing (DON) stated, Staff are expected to check their carts at the end of each shift and remove any expired medications. Observation on 05/04/2026 at 10:15 AM, revealed the thermometer in the refrigerator in the second-floor medication room showed a temperature of 58 degrees Fahrenheit. (Photographic evidence). Interview on 05/04/2026 at 10:17 AM Staff A, RN stated the temperature was increased to thaw out (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	insulin for a resident. During a second interview on 05/04/2026 at 10:30 AM Staff A, RN stated: I took the Humalog insulin out the refrigerator for [Resident #47], the thermometer was of accurate temperature, but the door was open which cause the temperature in the refrigerator to elevate. I have no control over the temperature in the refrigerator. Interview on 05/04/2026 at 12:46 PM the Pharmacist stated: The medication room refrigerator temperature should be maintained between 36–46 degrees F. I spoke with the nurse on the second floor, who stated that the temperature increased due to the refrigerator door being left open for an extended period. The exact amount of time required for the temperature to rise, I do not know. Review of the facility's undated policy titled Medication Storage indicate: Medications requiring refrigeration will be stored in a refrigerator that is maintained between 2 - 8 degrees Celsius (36 to 46 degrees F). i. Temperature will be checked daily to ensure it is within the specified range. If temperature is out of range, the refrigerator thermostat will be adjusted.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to accommodate a resident's choice for food preferences for one resident (Resident number 22) out of one resident reviewed for choices and preferences. There were a total of 111 residents residing in the facility at the time of this survey. The findings included:Record review of the Resident Rights Policy and Procedure (Revised January 2022, Reviewed January 2026) documented: Policy Statement-Employees shall treat all residents with kindness, respect and dignity. Policy Interpretation and Implementation-1) Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a) a dignified existence; b) be treated with respect, kindness and dignity and e) self-determination; preferences.Review of the Resident Nutrition Services Policy and Procedure (Revised March 2024, Reviewed January 2026) documented: Policy Statement-Each resident shall receive the correct diet, with preferences accommodated as feasible and shall receive prompt meal service. Policy Interpretation and Implementation-4) Nursing staff and the clinical dietitian will assess each resident's food likes, dislikes and eating habits.Review of the Resident Food Preferences Policy and Procedure (Effective January 2023, Reviewed January July 2026) documented: Policy Statement-Individual food preferences will be assessed upon admission, quarterly and monthly with interdisciplinary team review. Modifications to diet will only be ordered with the resident's or representative's consent. Policy Interpretation and Implementation-1) Upon the resident's admission the Dietitian/Food Service Manager or nursing staff will identify a resident's food preferences. Preferences are recorded in the tray ticket system by the Dietitian/Food Service Manager and updated as resident choices change and 2) Staff will interview the resident directly to determine current food preferences based on history and life patterns related to food and mealtimes.Initial observation and interview with Resident number 22 on 05/04/2026 at 09:52 AM revealed the resident sitting up in bed and watching tv. She stated, They don't give me food for my Crohn's disease. I can't have fried foods, gravy or vegetables with the skin on them. I can eat chicken and pork. I don't eat their fish because it has the skin on it and is salty. I eat a peanut butter and jelly sandwich every day for lunch and dinner. I will only eat breakfast, that is my best meal.Second observation and interview with Resident number 22 on 05/04/2026 at 12:39 PM revealed the resident sitting up in bed, eating lunch with the television on. The resident's lunch food tray consisted of: Baked Chicken with gravy, [NAME] potatoes with skin on, Mixed Vegetables, Cream of Potato Soup, Two Peanut Butter and Jelly sandwiches and Vanilla wafers for dessert. The resident only ate the mixed vegetables and one of the peanut butter and jelly sandwich. Review of the meal ticket documented the liked foods were two peanut butter and jelly sandwiches and the disliked foods were no gravy.Third observation and interview with Resident number 22 on 05/05/2026 at 07:37 AM revealed the resident sitting up in bed, eating breakfast and with the television on. The resident's breakfast food tray consisted of: Scrambled eggs, Toast, Two Croquettes, Cream of Wheat, Almond Milk, Apple Juice, Coffee. She stated, I told the dietitian on yesterday, that I don't drink milk. I don't know why they keep giving it to me.Fourth observation and interview with Resident number 22 on 05/05/2026 at 12:27 PM revealed the resident sitting up in bed, eating lunch and with the television on. The resident's lunch food tray consisted of: Pork Roast with gravy, [NAME] Beans, Yucca, Vanilla Pudding, Tropical Fruit, Cup of Grapes, Honeydew Melon, Strawberries, Navy Bean Soup, 2 Peanut Butter and Jelly sandwiches and Apple Juice. The resident only ate the green beans, strawberries, pudding and 2 spoonfuls of the yucca. She stated, I can't eat the pork with the gravy on it.Record review of the Demographic Face Sheet for Resident number 22 documented the resident was admitted on [DATE] with a diagnosis of Crohn's disease, irritable bowel syndrome, atrial fibrillation, hypertension, insomnia, major depressive disorder and anxiety.Review of the Minimum Data Service (MDS) admission assessment dated (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE] for Resident number 22 documented the resident was able to make her needs known, required dependent assistance for adls (activities daily living), partial to moderate assistance for eating and was prescribed a Therapeutic diet.Review of the Physician's Order Sheets (POS) dated February 2026 to May 2026 for Resident number 22 documented the resident was on a NAS (No Added Salt) diet with a regular texture and a Thin consistency.Review of the Gastro-intestinal care plan (written 02/07/2026; reviewed and updated) for Resident number 22 documented the following: Focus: Resident has an alteration in gastro-intestinal status related to Irritable Bowel Syndrome with constipation, Crohn's Disease; Goal: The resident will remain free from discomfort, complications or signs and symptoms related to gastro-intestinal alterations through review date; Interventions: Diet as ordered; Discuss with the resident/family /caregivers any concerns/fears/issues related to gastro-intestinal distress; Encourage the resident to avoid alcohol, smoking, coffee (even decaffeinated), fatty foods, chocolate, citrus juices, [NAME], tomato products, garlic and onionsReview of the Nutrition care plan (written 03/02/2026; reviewed and updated) for Resident number 22 documented the following: Focus: Resident is at risk for altered nutrition/hydration status related to diagnoses: anemia, Crohn's disease, atrial fibrillation, hypertension, inadequate intake and malnutrition risk; Goals: Resident will maintain present weight (+/-) 3 percent per month thru next review date and Resident will not show signs and symptoms of dehydration thru next review date; Interventions: Provide diet as ordered and tolerated to reduce Malnutrition risk, NAS Regular thin liquids sandwich lunch and dinner and Honor food preferences and update as needed.Review of the Nutrition Full admission assessment dated [DATE] for Resident number 22 documented the resident's food intake was fair 25-50% to good 50-75%.Fifth observation and interview with Resident number 22 on 05/06/2026 at 07:44 AM revealed the resident sitting up in bed, eating breakfast with the television on. The resident's breakfast food tray consisted of: Cornflakes, Almond Milk, Scrambled eggs with cheeses, Toast, Cinnamon roll, Oatmeal, Peanut Butter and Jelly sandwich, Coffee and apple juice. She stated, I can't eat the eggs with cheese. I told the dietitian, no cheese. She proceeded to start crying and saying, I need to leave here and go somewhere else. They won't give me what I need to eat for my Crohn's disease. Photographic evidence submitted. Review of the meal ticket documented the liked foods were two peanut butter and jelly sandwiches and the disliked foods were no cheese.Sixth observation and interview with Resident number 22 on 05/06/2026 at 12:37 PM revealed the resident sitting up in bed, eating lunch with the television on. The resident's lunch food tray consisted of: Picadillo, Mashed Potato, Plantains, Black Bean Soup, Diced Pears, Butterscotch Pudding, Two Peanut Butter and Jelly sandwiches and Apple Juice. The resident ate the diced pears, butterscotch pudding and only ate a half of one of the plantains. She stated, I can't eat that meat. It would hurt my stomach more.Seventh observation and interview with Resident number 22 on 05/07/2026 at 07:37 AM revealed the resident sitting up in bed, eating breakfast with the television on. The resident's breakfast food tray consisted of: Scrambled eggs, Sausage patty, Cheese grits, Cornflakes, Almond Milk, Toast, Coffee and Cranberry juice.Interview with Staff C, Registered Dietitian (RD) Eligible on 05/07/2026 at 07:58 AM. She stated, She is on a therapeutic diet and receiving snacks and supplements. She is on a NAS diet and receives snacks twice a day, cookies and puddings. She receives a diabetic supplement twice a day. She consumes 50-75% of her meals and more than 50% of her snacks. I am the one that is visiting her and charting on her. I am aware of her having Crohn's disease. She is not to eat something fatting, nothing with seeds. We provide her everything she wants. The RD eligible became confrontational when discussing the nutritional status of the resident.Interview with the Certified Dietary Manager (CDM) on 05/07/2026 at 08:32 AM. He stated, I know she don't like fish. She doesn't like hard boiled eggs and we give her scrambled eggs. She doesn't like ham, so we sent her sausage for today. She doesn't like rice, no fried foods, no greasy foods.Interview with Staff D, Certified Nursing Assistant (CNA) on 05/07/2026 at 10:48 AM via Spanish translator. She revealed, she say okay with the food and other days she will say I want a sandwich. There are certain days she doesn't eat at all. Most days the tray has most of the food still (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on it. She will request a peanut butter and jelly sandwich.Interview with Staff E, Registered Nurse on 05/07/2026 at 10:56 AM. He stated, She is alert and oriented times threes. She is dependent for adls and can feed herself. Sometimes in the morning, she will call the nurse to ask for something else to eat. I have only worked with her two times. Once this week and once a couple of weeks ago. She eats 75% of her food.Interview with the Registered Dietitian (RD) Consultant on 05/07/2026 at 11:01 AM. She stated, I'm aware of situation but I have not been following her. She is visited frequently by [ ] Staff C, Registered Dietitian Eligible and [ ] Certified Dietary Manager. The diet should be very individualized when they have Crohn's disease and Irritable bowel syndrome.Review of the 4 cycle menus dated May 4-7, 2026 revealed no modifications were made to accommodate the resident's Crohn's disease.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, records reviewed and interviews facility staff did not properly position indwelling catheter tubing for two residents (Resident #79 and Resident #86) out of two sampled residents with indwelling urinary catheters. The indwelling urinary catheter tubing for Resident #79 and Resident #86 formed circular loops, which prevented urine from flowing freely and increased the risk for catheter-associated urinary tract infections and other serious medical issues. Seven residents with indwelling urinary catheters lived in the facility at the time of the survey. The findings included: Resident #79 Observation on 05/04/2026 at 7:50 AM and on 05/05/2026 at 8:19 AM, Resident #79 was in bed it was noted that the resident's suprapubic indwelling urinary catheter tubing formed a circle and contained urine that appeared cloudy. (Photographic evidence) Review of Resident # 79's clinical records revealed the resident was initially admitted to the facility on [DATE] and readmitted on [DATE]. Clinical diagnoses include but are not limited to personal history of Urinary Tract Infection (UTI) and Stage 4 Pressure Ulcer of sacral region. Review of the Quarterly Minimum Data Set (MDS) reference dated 04/12/2026 revealed Resident # 79 had a Brief Interview of Mental Status score of 15 out of 15 which indicated no cognitive impairment. Functional status indicated the resident is dependent for toileting hygiene and had an Indwelling catheter. Record review of Resident # 79's Care Plans that started on 11/26/2024 and revised on 12/22/2024 for a suprapubic catheter related to diagnosis of neurogenic bladder with interventions that included: Check catheter tubing for patency as indicated/needed, position catheter bag and tubing to promotes drainage, and monitor for cloudiness and to report abnormalities to nurse/Medical Doctor as needed. Record review of Resident # 79's physician's order sheets revealed an order dated: 04/20/2026 for Suprapubic catheter care every shift and an order dated 04/30/2026 for Mupirocin External Ointment 2 % (Mupirocin). Apply to Suprapubic catheter area topically two times a day for superficial skin infection for 14 Days.Record review of Resident # 79's urology consult dated 04/09/2026 plan included Non-Pharmacological Interventions (Symptom-focused): Neurogenic bladder / chronic urinary retention: Maintain suprapubic catheter for continuous bladder drainage. Ensure proper catheter positioning and gravity drainage at all times. Resident # 86Observation on 05/04/2026 at 7:53 AM and on 05/05/2026 at 8:55 AM, Resident # 86 was lying in bed with the tubing for the indwelling urinary catheter coiled and urine present throughout the tubing. (Photographic evidence).Review of Resident # 86's clinical records revealed the resident was admitted to the facility on [DATE] and readmitted on [DATE]. Clinical diagnoses included but not limited to Benign Prostatic Hyperplasia with lower urinary tract symptoms and Neuromuscular Dysfunction of Bladder. Review of Resident #86's Quarterly Minimum Data Set (MDS) reference dated 03/04/2026 revealed Resident # 86 had a Brief Interview of Mental Status score of 03 out of 15 which indicated severe cognitive impairment. Functional status indicated the resident required substantial/maximal assistance for toileting hygiene and had an Indwelling catheter. Review of Resident # 86's care plans with start date 05/28/2025 revised on 08/18/2025 for urinary catheter secondary to a diagnosis of Neurogenic Bladder, interventions included: Change urinary catheter as needed, monitor/document for pain/discomfort due to catheter, and monitor/record/report to medical doctor for signs and symptoms of UTI. Review of Resident # 86's physician's order sheets included an order dated 05/28/2025 for indwelling urinary catheter care every shift and an order dated 04/30/2026 for indwelling urinary catheter. Diagnosis: Neurogenic Bladder. During an interview conducted on 05/06/2026 at 3:22 PM, with translation assistance provided by another surveyor on the team; Staff I (Registered Nurse) stated that catheter tubing should be positioned straight to prevent obstruction. On 05/07/2026 at 2:21 PM, the Infection Preventionist stated: Catheters are to be positioned straight to prevent UTI.On 05/07/2026 at 2:35 PM, the Director of Nursing (DON) was informed of the identified concerns. The DON stated: (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Indwelling urinary catheters are to be positioned as straight as possible for the flow of urine to prevent obstruction that can cause infection.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106034	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jackson Gardens Health and Rehabilitation Center	1861 NW 8th Avenue Miami, FL 33136

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews, facility staff did not consistently implement infection prevention and control procedures for one (Resident #81) out of three sampled residents receiving oxygen and for two (Residents #79 and Resident #8) out of three sampled residents out of the thirty-three residents with orders for Enhanced Barrier Precautions, as evidenced by: 1)The humidifier for Resident #81 had not been replaced in over seven days. 2) Facility staff did not properly dispose of biohazardous material after Resident #79's dressing change. 3) Staff did not adhere to Enhanced Barrier Precautions by failing to wear required Personal Protective Equipment when providing hygiene care and linen changes for Resident #8. These deficient practices increased the risk of infections and disease spreading.There were a total of 111 residents residing in the facility at the time of this survey. The findings included: Resident # 81Observation on 05/04/2026 at 10:55 AM revealed Resident # 81 in bed with oxygen in progress at 2 Liters per minute (LPM) via nasal cannula. The humidifier canister was dated 4/26/26. (Photo evidence).A follow up observation on 05/05/2026 at 10:54 AM revealed Resident # 81 in bed with oxygen in progress at 2 Liters per minute (LPM) via nasal cannula and the humidifier canister was dated 4/26/26 (Photo evidence). Record review of Resident # 81's clinical records revealed the resident was admitted to the facility on [DATE] with diagnosis that include but not limited to Chronic Respiratory Failure with Hypercapnia and Chronic Obstructive Pulmonary Disease (COPD). Record review of Resident # 81's annual Minimum Data Set (MDS) reference dated 02/18/2026 section for Cognitive Pattern indicated Resident # 81 had a Brief Interview of Mental Status (BIMS) score of 15 out of 15 indicating no cognitive impairment the section for Special Treatments Procedures, and Programs indicated the resident received oxygen therapy. Review of Resident # 81's care plan for oxygen therapy related to respiratory failure, COPD starting on 04/19/2026 with interventions that included: Change humidifier/ cannula/ or mask per protocol. Review of Resident # 81's physician's order sheet revealed an order dated 06/24/2024 to change humidifier bottle once weekly on Sunday during the night shift and as needed. Review of the facility's policy and procedure titled, Infection Prevention and Control Program Revised: January 2024 revealed Policy: An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Resident # 79Observation on 05/06/2026 at 9:48 AM, Staff I, Registered Nurse (RN), performed a suprapubic catheter dressing change for Resident #79. Staff I, RN removed the soiled dressing, which contained bloody drainage, and placed it in the resident's bedside trash can. After completing the procedure, Staff I, RN performed hand hygiene, left the soiled dressing in the trash and exited the room. A follow up observation on 05/06/2026 at 10:48 AM revealed the trash remained in Resident # 79's trash can. (Photo evidence).Record review of Resident 79's clinical record revealed the resident was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis that include but not limited to Urinary Tract Infection and Neuromuscular Dysfunction of Bladder.Review of Resident # 79's physician's order sheets revealed an order dated 5/5/2026 for Enhanced Barrier Precautions.Review of Resident # 79's Minimum Data Set (MDS) reference dated 04/12/2026 indicated the resident had no cognitive impairment, dependent on toileting and had an indwelling catheter. Review of Resident # 79's clinical records revealed the resident was care planned for Enhanced Barrier Precaution related to Suprapubic catheter use starting on 11/26/2024 and revised on: 01/07/2025 with interventions that included: Maintain enhanced barrier precaution as indicated during dressing, bathing/showering, transferring. providing hygiene, changing linens, changing briefs or assisting with toileting, device care or IV access line care, urinary catheter care, feeding tube care, tracheostomy/ventilator care, ostomy care, or during wound care.Review of Resident # 79's physician's order sheets revealed an order dated 5/5/2026 for Enhanced Barrier Precautions. Record review of the facility's policy and procedure titled, Infectious (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Waste, Handling of reviewed January 2026 revealed The performance of this procedure may involve potential and/or direct exposure to blood, body fluids, infectious diseases, air contaminants, and/or hazardous chemicals. Purpose: The purpose of this procedure is to provide a definition of and guidelines for the safe and appropriate handling of infectious waste. Definition and Classification: Infectious (or clinical) waste includes items contaminated with blood, body fluids, tissues, organs, cultures of infectious agents, or sharps capable of transmitting disease. Differentiated from offensive waste (non-infectious but unpleasant) and general waste (non-clinical). Preparation: 1. Assemble the equipment and supplies as needed. General Guidelines: Infectious waste must be placed in rigid, leak-resistant, clearly labeled containers marked with the biohazard symbol, Red plastic bags.4.BIOHAZARD label (if red bags or containers are not used); and Personal protective equipment (e.g., gowns, gloves, mask, etc., as needed). Resident # 8On 05/06/2026 at 10:33 AM Staff J, Certified nursing assistant (CNA) was observed wearing a mask and gloves while providing hygiene care for Resident # 8.Review of Resident #8's clinical record revealed the resident was admitted to the facility on with diagnosis that include but not limited to: Gastrostomy and Dependence on Renal Dialysis.Record review of Resident #8's quarterly Minimum Data Set (MDS) reference dated 03/13/2026 revealed Resident # 8 had a Brief Interview of Mental Status (BIMS) score of 5 out of 15 indicating severe cognitive impairment and was dependent for toileting.Record review revealed Resident # 8 care plan for Enhanced Barrier Precautions starting on 09/12/2025 interventions that included: Maintain enhanced barrier precaution as indicated during hygiene care and changing linens.Record review of a physician's order sheet revealed Resident # 8 had an order dated 04/22/2026 for Enhanced Barrier Precaution: Encourage and assist resident to maintain enhanced barrier precautions for Percutaneous Gastrostomy, dialysis catheter and Wound.Review of the facility's policy and procedure titled, Enhanced Barrier Precautions Reviewed: 1/3/26; Revised: 4/1/2024 indicated: It is the policy of this facility that Enhanced Barrier Precautions, in addition to Standard and Contact Precautions will be implemented during high-contact resident care activities when caring for residents that have an increased risk for acquiring a Multi Drug-Resistant Organism (MDRO) such as a resident with wounds, indwelling medical devices or residents with infection or colonization with an MDRO. Procedures: Enhanced Barrier Precautions (EBP) consists of the use of gowns and gloves for high-contact care activities which include but may not be limited to: Providing hygiene and changing linens. During an interview on 05/06/2026 at 3:22 PM, with translation assistance from another surveyor regarding the identified concerns, Staff I, RN stated that Resident #81 receives continuous oxygen therapy at a rate of 2 liters per minute, and the tubing and humidifier are changed on Sunday during the night shift or as needed. Staff I, RN acknowledged that the humidifier had not been changed in more than a week. Staff I, RN revealed Resident # 79 is receiving dressing changes with ointment due to a skin infection and the dressing that was removed contained blood and stated: I should have placed it in a Biohazard bag and bin. During an interview on 05/06/2026 at 3:33 PM Staff J, Certified Nursing Assistant (CNA) was asked about the facility's policy and procedure for residents under enhanced barrier precaution, Staff J stated: I know I made a mistake. I was supposed to wear a gown when taking care of [Resident # 8]. I forgot. During an interview on 05/07/2026 at 2:21 PM the Infection Preventionist was informed of the identified concerns and stated: Staff are to change respiratory supplies as ordered for infection prevention. During a dressing change, Staff are to dispose of biohazard materials into a red bag and into the biohazard bin in the soiled utility room. EBP is ordered for residents who have a high risk of acquiring or transmitting organisms or with colonized infection like open wounds with secretion, tracheostomies, PEG, dialysis, and catheter. When staff provide hygiene care to these residents they are to wear gowns, gloves, and masks for infection prevention. On 05/07/2026 at 2:35 PM the Director of nursing (DON) stated, Nursing staff are responsible to change the respiratory care devices weekly and as needed for infection prevention because due to the humidity bacteria can grow. Staff are to put any bloody materials in the red bag and into the soiled utility room. Staff are required to wear gowns, gloves, and masks during high contact activities.