

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

Printed: 08/28/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2024
NAME OF PROVIDER OR SUPPLIER North Dade Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1255 NE 135th Street North Miami, FL 33161	
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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31581 Based on record review and interviews, the facility failed to ensure adequate information was documented in the medical records for one (Resident #2) out of three residents reviewed for admission, transfer and discharge rights. As evidenced by the medical records for Resident #2 was not documented in accordance with accepted professional standards/practices, that require residents' records to be complete, accurate, organized and contain sufficient information. The facility's staff were unable to provide factual information related to Resident # 2's status after leaving the facility to the hospital via emergency services. The findings included: Review of the Demographic Face Sheet for Resident #2 documented Resident #2 was admitted on [DATE] with a diagnosis that include but not limited to diabetes mellitus, bipolar disorder, atherosclerotic heart disease, dementia, cerebral infarction and hypertension. The resident was discharged to the hospital on 8/02/2023. Review of the Minimum Data Set (MDS) Admission assessment dated [DATE] for Resident #2 documented the resident's Mental Status (BIMS) Summary Score was 01, indicating severe cognitive impairment, required extensive assistance for ADLs (activities of daily living). Review of the Physician's Orders Sheet (POS) dated May 2023 through August 2023 for Resident #2 revealed the resident received Insulin for diabetes mellitus and a blood thinner to prevent blood clots. Review of the progress notes for Resident #2 documented the following: On 8/2/2023, around 8:59 resident had a complaint with pain in the left neck and right-side pain. After assessment, vital signs were taken, weakness on right side slurred speech was noted. Call was placed to the MD (medical doctor). New order was received to transfer resident to a local hospital via emergency services with diagnosis abnormal blood pressure. Emergency services arrived shortly after and transferred resident via stretcher in a gown accompanied by three attendants. There was no further documentation to indicate if the facility's staff communicated with the receiving hospital to verify if the resident made it to the hospital. There was no documentation to indicate if the facility's staff communicated with the resident's family/representative regarding the residents status. There was no information documented to indicate if the facility followed up at any point either with the resident's representative or the hospital to check on the resident's status. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 106133	Facility ID: 106133 If continuation sheet Page 1 of 4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2024
NAME OF PROVIDER OR SUPPLIER North Dade Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1255 NE 135th Street North Miami, FL 33161	
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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Hospital Transfer Form for Resident #2 dated 8/02/23 documented the resident was transferred to a local hospital for abnormal vital signs. On 6/04/24 at 8:25 AM, interview with Registered Nurse (RN), MDS (Minimum Data Coordinator). She stated, His discharge care plan was to be discharged back to the community. His BIMS score was 01 and he was not able to make his decisions. He was discharged to the hospital on 8/02/23 due to a stroke. On 6/04/24 at 8:52 AM, interview with the Social Services Director. She stated, I am responsible for discharge back to the community ALF (assisted living facility), ILF (independent living facility), home or transfer to another facility. Social services are responsible for discharge care planning. At the beginning he was here for short term. He was discharged to the hospital. I didn't do his discharge; Nursing did his discharge. On 6/04/24 at 9:07 AM, interview with the Marketing Director via telephone. She stated, My responsibility is as a liaison between the facility and the hospital. I only do clinical. I sent the paperwork and the facility let me know if they can take the patient. We never said that we were not going to take him back. We explained to the case manager that we did not have a bed for him at the moment. We asked them to give us more time. When they call, they expect for you to accept the patient on that same day. They were discharging the resident and did not do any discharge planning. I don't know if there was a denial of insurance. Any correspondence with the case manager would be with Admissions. You can ask [Admissions Director] if there was a denial letter for him. Denied saying to cite reason of not accepting patient back is that 'they learned the patient has assets'. If he has assets he will not qualify for Medicaid but would qualify for Medicare. On 6/04/24 at 9:55 AM, interview with the Admissions Director. She stated, My responsibility is once the Marking Director gets the referral, we take the referral and send it to the Director of Nursing to review it. Once we get the approval we then go and run the financial and get an authorization from the insurance. He was discharged on [DATE], he went to [local hospital]. When I checked the referral system, [] there were no results found for him. There was never a referral back to us for us to readmit him. If there was, he would be found in the system. On 6/04/24 at 10:25 AM, interview with the Business Office Manager. She stated, My responsibilities are on a day to day to update the census, manage resident trust accounts, Medicaid pending doing the applications and documents needed, update payor trees such as primary, secondary payor sources and request authorization for long term care here in the facility. When he went to the hospital, he had 11 days of Medicare remaining. His primary payor source was Medicare. He was supposed to return from the hospital. I wouldn't know if he had any assets. [] who is the Medicare Coordinator, would know that information and her office is at [], one of our sister facilities. On 6/04/24 at 11:03 AM, interview with the Medicare Coordinator via telephone. She stated, When we applied for Medicaid for him in 2023, he was denied due to him having assets. He was over assets. If he had more than \$2,000, he would be disqualified. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2024
NAME OF PROVIDER OR SUPPLIER North Dade Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1255 NE 135th Street North Miami, FL 33161	
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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/04/24 at 11:06 AM, interview with the Admissions Director. She stated, I went into another [local hospital] portal and the patient was at another [local hospital]. We don't know how he was sent there. There was a referral sent to us on 9/26/23 from the [local hospital] in the afternoon and I sent it to the DON. The DON answered the following day and said okay to admit him. I went back on the hospital portal and put the patient is accepted clinically. Please let us know when the patient is ready for discharge. They never answered back to us to send the patient back. On 6/04/24 at 12:37 PM, interview and record review with the current Director of Nursing. He stated, I was not working here, when this resident went out to the hospital. I started working here in September 2023. On 8/02/23, around 8:59 resident complained about pain in left of neck and right-side pain. After assessment Vital signs, weakness on right side slurred speech Call placed to MD, new order received to transfer resident to [local hospital] via [emergency services] with diagnosis of abnormal BP (blood pressure). [emergency services] arrived shortly after and transferred resident via stretcher in a gown accompanied by three attendants. When a resident is sent to the hospital, a follow-up call by nursing should be made to the hospital to confirm if the resident was admitted . I don't see any notes that say that a call was made to the hospital. Further review of the medical records requested from the local hospital that Resident #2 went to when he was transferred from the facility via local emergency department. The records revealed Resident #2 was admitted to the hospital on 08/02/2023 and discharged on [DATE]; the records documented: The patient clinical condition and symptoms improved, stable to be discharged back to skilled nursing facility. However further review indicated Resident #2 remained in the hospital until 08/23/2023 and was discharged to another nursing home.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2024
NAME OF PROVIDER OR SUPPLIER North Dade Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1255 NE 135th Street North Miami, FL 33161	
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 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. 31581 Based on record review and interview, the facility's quality assurance and assessment committee failed to identify quality concerns in order to implement effective plans of action related to maintaining accurate medical records resulting in repeated deficient practice. The facility was cited F842- Resident Records ? Identifiable Information in March 2023; again during this survey. The findings included: Record review of the facility's Quality Assurance Performance Improvement (QAPI) Program Policy and Procedure (issued June 2021) documented the following: Policy-It is the policy of this facility to develop, implement and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. Policy Explanation and Compliance Guidelines: 1) The QAPI program includes the establishment of a Quality Assessment and Assurance (QAA) Committee and a written QAPI Plan; 2) The QAA Committee shall be interdisciplinary and shall: b) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program; 3) b) Policies and procedures for feedback, data collection systems and monitoring, c) Process addressing how the committee will conduct activities necessary to identify and correct quality deficiencies. Key components of this process include, but are not limited to, the following: Tracking and measuring performance, Identifying and prioritizing quality deficiencies, Systematically analyzing underlying corrective action or performance improvement activities and Monitoring and evaluating the effectiveness of corrective action/performance improvement activities and revising as needed. Review of the Quality Assurance and Performance Improvement (QAPI) Committee Meeting Sign-in Sheets dated 3/25/24, 4/29/24 and 5/29/24 documented the facility had a QAA Committee meeting monthly. Attendees included: Administrator, Medical Director, Director of Nursing (DON), Social Services Director, Rehab Therapy Director, Maintenance Director, Business Office Manager, Admissions Director, Human Resources Manager, MDS (Minimum Data Set) Coordinator, Pharmacy and Licensed Nurses. On 5/04/24 at 2:41 PM, interview with the Administrator/QAA. She stated, The QAA Committee meets monthly on the second Wednesday of the month. The committee consists of the Medical Director, Administrator, DON and department heads. The purpose of QAA is to talk about if there are any issues, how to fix them, special projects we want to implement, and how to move the building forward. Every department gives their report, and we discuss how to improve.		