STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106133	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Dade Nursing and Rehabilitation Center	1255 NE 135th Street North Miami, FL 33161

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34007 Based on observations, interview, and record review the facility failed to promote and ensure residents are treated in a dignified manner and treated with respect; for four out of the 36 residents sampled. (Resident #201, Resident #159, Resident #48 and Resident #76). As evidenced by 1) staff observed standing while feeding Resident #201 with breakfast. 2)Resident #201 and 159 did not receive their food tray until half an hour after the other two roommates. 3) Staff referred to the residents that need assistance with eating as feeders and 4) Resident #48 in view of staff and other residents was wearing no pants with genitals exposed and Resident # 76 was wearing no socks or shoes propelling in wheelchair around the facility. There were 208 residents residing in the facility at the time of the survey. The findings included: 1) Observation on 07/29/2024 at 12:26 PM trays arrived for residents that ate in rooms, one nurse and three Certified Nursing Assistants (CNAs) started serving trays immediately. Further observation revealed that Resident # 102 and Resident # 159 did not receive their meal trays, but their roommates had received meal trays and were eating. On 07/29/24 at 12:51 PM, Staff A, CNA revealed at the time of the meals depending on the area assigned, she can have one or three feeders that needs assistance. If two feeders are in the same room, after finishing with him/her, the other feeder is assisted. Observation on 07/29/24 at 12:54 PM the tray for Resident #201 was served and assisted with his meal. Observation on 07/29/24 at 12:55 PM the tray for Resident #159 was brought by the kitchen staff. On 07/29/24 at 12:55 PM Staff C, Licensed Practical Nurse (LPN) stated: At the time of the meals all the CNAs have been assigned their section and they assist all the feeders that they have in their section. If there are not enough staff, they have to wait a few minutes. Record review of Resident #201's demographic face sheet revealed an admitted [DATE] with diagnosis that included unspecified dementia. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Discharge Return Anticipated Minimum Data Set (MDS) dated [DATE] section C for cognitive status revealed a Brief Mental Status (BIMS) score of undetermined. Section GG for functional status revealed dependent for eating. Section K for swallowing status revealed no or unknown. Review a care plan initiated on 5/2/2024 and Target Completion Date on 8/23/2023 for diagnosis of Parkinson's and is at risk for injury and decline in function related to tremors and involuntary muscle movements On 07/30/24 at 07:53 AM Staff B was observed standing while assisting Resident #201 with his breakfast; when asked if she knew how to assist the residents with their meals she stated, I always assist the resident standing up, when I do not find a chair. On 08/01/24 at 07:46 AM Resident #159 stated he has been living in the facility for over a year already. He reported: Sometimes it takes a while for the staff to come, I assume it's because they are busy. When they serve the food sometimes some residents had to wait a little longer than usual ones because the staff are busy or there are not enough. Review of Resident #159's clinical records indicated an initial admitted [DATE]. Clinical diagnoses include but not limited to Chronic obstructive pulmonary disease. Review of Resident #159's Significant Change Minimum Data Set (MDS) dated [DATE] section C for cognitive status revealed a Brief Mental Status (BIMS) score of 15 out of 15; indicating Resident # 159 is cognitively intact. 45019 During observation on 07/29/24 at 08:20 AM Resident #48 was in front of room door sitting in wheelchair with no pants on and genitals exposed; Resident # 48 stated: I need some clothes. 07/29/24 at 08:35 AM Licensed Practical Nurse (Staff K) called for help from other staff to get the resident some clothes, no one responded. 07/29/24 at 08:38 AM staff member came to see what Staff K needed. Staff K, spoke with the staff member and they both entered the resident's room to give care. Review of the medical records for Resident #48 revealed the resident was admitted to the facility on [DATE]. Clinical diagnoses included but not limited to: Schizophrenia, major depressive disorder, anxiety disorder, vascular dementia, unspecified severity, with other behavioral disturbance. Review of the Physician's Orders Sheet for July 2024 revealed Resident #48 had orders that included but not limited to: Haloperidol by mouth in the morning and evening related to schizophrenia. Depakene oral solution by mouth two times a day related to schizophrenia. Ativan tablet by mouth at bedtime related to anxiety disorder. Trazodone tablet 1 tablet by mouth every morning and at bedtime related to major depressive disorder. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident # 48's Quarterly Minimum Data Set (MDS) dated [DATE] revealed: Section C for Cognitive Patterns documented Brief Interview for Mental status score 6, on a 0-15 scale indicating the resident is cognitively impaired. Section E for Behavior documented resident reject evaluation or care one to three days. Section N for medications documented resident is taking antidepressants, antianxiety and antipsychotic medications. Resident #76 On 07/29/24 at 08:40 AM Resident #76 was observed seated in a wheelchair with no shoes or socks on propelling himself around the facility using his feet. Several staff were in attendance on the hallways; at 08:55 AM the Rehabilitation Director brought the resident a pair of blue shoe socks to put on. Review of the medical records for Resident #76 revealed the resident was readmitted to the facility on [DATE]. Clinical diagnoses included but not limited to: Metabolic Encephalopathy Record review of Resident # 76's Quarterly Minimum Data Set (MDS) dated [DATE] revealed: Section C for Cognitive Patterns documented Brief Interview for Mental status score 14, on a 0-15 scale indicating the resident is cognitively intact. Interview on 07/31/24 at 07:51 AM assistant Director of Nursing (ADON) stated we need to do an in-service on dignity, making sure staff is documenting the behaviors of the resident, especially in this facility, we have to make sure the residents are being provided the care they need at all times, if the resident is resistant to care we notify the physician (MD) for orders and directions to help aid in the care of the resident. Interview on 07/31/24 at 11:15 AM; the 7:00 AM to 3:00 PM A Wing Certified Nursing Assistant (Staff H) stated: If I see a resident with no clothes, no shoes on, whether the resident is assigned to me or not I will help the patient to get what they need. If the patient is a difficult patient, I will ask someone to help me with the patient. Interview on 07/31/24 at 11:49 AM Certified Nursing Assistant (Staff I) stated: If I observe a resident walking around with no clothes or shoes on, I will take the resident back to their room and dress them and make sure they are taken care of. Interview on 07/31/24 at 12:03 PM; Certified Nursing Assistant (Staff J) from the 7:00 AM to 3:00 PM shift, stated: if I see a resident in the facility walking around with no footwear or clothes on, I will approach the resident, redirect them to their room and put clothes and shoes on the resident. Review of the facility policy titled Promoting and Maintaining Resident Dignity Revision Date 4/2023 states: It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. Compliance Guidelines: All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights. When interacting with resident, pay attention to treat the resident as an individual.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34007 Based on interview and record review, the facility failed to accurately code the Minimum Data Set (MDS) for one resident (Resident #145) out of the 36 sampled residents. There were 56 residents residing in the facility that are smokers. The finding included: Review of Resident # 145's admission records an initial admitted [DATE]. Record review of the Annual Minimum Data Set (MDS) dated [DATE] Sections C-Cognitive Patterns/Brief Interview for Mental Status (BIMS) was 05 out of 15, indicating severe cognitive impact. Section J-Health Conditions item J1300. Current Tobacco Use was checked No. Record review of Care plan dated Date 6/16/2024, Target Completion Date 9/14/2024 revealed that the facility had not done a care plan for the resident. Interview with MDS Coordinator on 07/31/24 at 02:23 PM. she stated: This was coded by my assistance who is no longer working in the facility. If the residents is not coded properly in the MDS it would not create the care plan thus the reason why there is not a smoker care plan. Review of the facility's Policy & Procedure titled Resident assessment dated ,d+[DATE] documented: It is the policy of the facility to the following procedures related to the proper documentation and utilization of a resident's Minimum Data Set (MDS) to ensure a comprehensive and accurate assessment of residents will be completed in the format and in accordance with time frames stipulated by the Department of Health Service Center for Medicare and Medicaid Services. This assessment system will provide a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacities and assist staff to identify health problems for care plan development. A resident's Minimum Data Set (MDS) is completed by interdisciplinary team. During the initial assessment period. date is collected by resident observation and communication as a primary source of information.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45019 Based on record review and interview, the facility failed to ensure a level 1 Preadmission Screening and Resident Review (PASRR) was completed accurately prior to readmission and failed to revise the screening following admission for one (1) Resident (#107). There were 208 residents residing in the facility at the time of the survey. The findings Included: During observations on 07/29/24 at 08:10 AM Resident #107 was in bed asleep. On 07/30/24 at 08:58 AM Resident # 107 was in bed awake. On 07/31/24 at 09:31 AM resident in bed asleep. Review of the medical records for Resident #107 revealed, the resident was admitted to the facility on [DATE]. Clinical diagnoses included but were not limited to: Major depressive Disorder and Anxiety Disorder and Unspecified psychosis not due to a substance or known physiological condition. Record Review of Resident #107's Level I PASRR (Preadmission Screening and Resident Review) documented Section I: PASRR Screen Decision Making: A: Mental Illness (MI) or suspected MI (check all that apply) - only Psychosis Disorder checked off. Findings based on documented history were-Section II Other indicators for PASRR screening Decision-Making: All checked - no. Does individual have validating documentation to support dementia or related Neurocognitive disorder - no. Section III Not a provisional admission. Section IV. No diagnosis or suspicion of Serious Mental Illness (SMI) or Intellectual Disability (ID) indicated. Level II PASRR evaluation not required. PASRR Level I completed by a Social Worker at the hospital on 12/06/2022. Record Review of Resident #107's Psychological Consultation dated 3/18/24 documented: resident previously, as unspecified psychosis, pseudobulbar affect, insomnia admits to good sleep/appetite, continued improvement of mood/psychotic signs and symptoms, denies thoughts at this time, appears alert and oriented, calm/cooperative Review of the Physician's Orders Sheet for July 2024 revealed, Resident #107 had orders the following medications by mouth that included but not limited to: Pramipexole Dihydrochloride Oral Tablet by mouth three times a day related to Parkinson's disease without dyskinesia, without mention of fluctuations. Mirtazapine Tablet at bedtime related to Major depressive disorder, Quetiapine Fumarate oral tablet in the evening related to unspecified psychosis not due to a substance or known physiological condition. Lorazepam oral tablet every 8 hours for anxiety. Record review of Resident # 107's Annual Minimum Data Set (MDS) dated [DATE] revealed: Section A 1500 resident is currently not considered by the state level II PASRR process to have a SMI or ID or a related condition. Section C for Cognitive Patterns documented Brief interview for mental status score (BIMS), 15 on a 0-15 scale indicating the resident is cognitively intact. Section I for Active diagnosis documented Anxiety disorder, Psychosis and Depression Disorder. Section N for Medications documented resident is taking antidepressants, antipsychotics, opioids and antianxiety medications. Section O for Special Treatments documented no special treatments received. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #107 's Care Plans Reference Date 06/02/24 revealed: Resident is at risk for drug related side effects due to use of psychotropic medications for the diagnosis of: Anxiety, Major Depressive, Psychosis: readmitted on [DATE] continue with of care. readmitted on [DATE] continue with of care. Date Initiated: 12/20/2022. Interventions include Assess for fall risk and precautions needed. Encourage activities as tolerated. Medicate as ordered. Psych consult/evaluation as needed. Monitor behavior and mood every shift and document. Monitor for behavior/mood changes. Observe for decline in function therapy screen as needed. Interview on 07/31/24 at 07:16 AM the Assistant Director of Nursing (ADON) stated: The initial PASRR level 1 only have psychotic disorder checked off, the anxiety and depression diagnosis was added when the resident came back from the hospital on 3/16/24. If the resident goes out to the hospital and returned with new diagnosis, the psychiatric physician (MD) sees the resident, assesses the resident, confirmed the diagnosis and then it gets added to the PASRR. The last time the resident was seen by the psychologist was on 3/18/24. According to the MD's assessment of the resident the Psychiatric MD did not add the anxiety and Depression diagnosis. The resident is currently receiving medications for major depression and anxiety. I will have the psych MD see the resident again, do a ten day look back for behaviors, and conduct a level one resident review and update the PASRR. Review of the facility's dated 3/2021 states: It is the policy of the facility to assure that all residents admitted to the facility receive pre-admission screening and resident review, in accordance with state and federal regulations.

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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** 34007 Based on interview and record review, facility failed to develop a Smoking care plan for Resident # 145 out of one resident reviewed for discharge care plan at the time of the survey. there were 208 residents residing in the facility at the time of survey. The findings included: Record review of Admission Record revealed the resident was admitted to the facility on [DATE]. Record review of Medical Diagnosis revealed the resident's diagnosis included, but were not limited to, Anemia, Hypertension, Arthritis, Cataracts, glaucoma, or macular degeneration and insomnia, Record review of Care plan dated Date 6/16/2024, Target Completion Date 9/14/2024 revealed that the facility had not done a care plan for resident Interview with MDS Coordinator on 07/31/24 at 02:23 PM, she reported the Minimum Data Set (MDS) was coded by her assistance who is no longer working in the facility. If the residents is not coded properly in the MDS it would not create the care plan thus the reason why there is no smoker care plan.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48906 Based on observations, record review and interviews facility failed to provide treatment and care for a skin condition for one resident (Resident #8) out of eleven residents sampled as evidenced by Resident # 8's right foot was noted to be dry and scaly while in bed. There were 208 residents residing in the facility at the time of survey. The findings included: On 07/29/24 at 8:50 AM an observation was made of Resident #8 in bed and the right foot exposed from under linens. Resident #8's right foot appeared dry and scaly. Record review of demographic sheet for Resident #8 revealed an admitted [DATE] and readmitted [DATE] with diagnosis that included Hemiplegia and Hemiparesis affecting left non-dominant side and Peripheral Vascular Disease. Record review of physician order sheet revealed orders dated 12/27/23 for Weekly Skin Check. Record review of Quarterly Minimum Data Set (MDS) dated [DATE] Section C (cognitive status) revealed a Brief Mental Status Score of 15 out of 15 indicated cognition was intact. Section GG (functional status) revealed Resident #8 was dependent for shower bathing and lower body dressing. Section M (Skin) revealed no Infection of the foot, no Open lesion(s) and no Diabetic foot ulcer(s). Record review of Care Plan Initiated on 5/17/2023 and revised on 11/27/2023 revealed Resident #8 had a problem with Impaired Skin Integrity with xerosis to bilateral legs. Goal for Resident to have no signs of infection and will decrease in size by next review date with a target Date of 11/13/2024. Interventions included: Inspect skin daily and report any changes, Weekly skin audit, and Use moisturizers, barrier creams and Wound/skin treatment as ordered. Record review of electronic record revealed a Weekly skin Audit dated 7/29/24 that indicated Resident #8's skin was dry, warm to touch, color normal for ethnicity, turgor appropriate for age. Currently no complaints of pain or discomfort. On 08/01/24 at 10:00 AM; Surveyor approached Staff O, Licensed Practical Nurse, (LPN) and asked if there were any treatments ordered for Resident #8's feet. Staff replied, there is no physician order for lotion or applications for {Resident #8's] feet at this time. Staff O, LPN was notified about the observation of Resident #8's dry scaly skin on the right foot and Staff O, LPN notified the Assistant Director of Nursing (ADON). On 08/01/24 at 10:03 AM; the ADON informed the surveyor that a skin assessment was completed after being notified by Staff O, LPN and it was determined that Resident #8's skin on lower extremities looked dry. I will notify the physician for a dermatology consult; a weekly skin assessment was completed on 7/29/2024 but no abnormalities were noted. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Policy titled Skin Integrity Date Implemented: 4/202 Date Reviewed/ Revised: 5/2023 Policy: It is the policy of this facility to provide proper treatment and care to maintain skin integrity. This policy pertains to the prevention and management of skin impairment. Policy Explanation and Compliance Guidelines: 3. Interventions for Prevention and to Promote Healing b. Topical treatments in accordance with current standards of practice will be provided for all residents who have a skin impairment.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45019 Based on observation, interview, and record review the facility failed to ensure the safety of two vulnerable residents (Resident #12 and Resident # 84) out of 40 residents sampled. As evidenced by an open toiletry bag full of shaving razors was observed on Resident #12's overbed table and a shaving razor was observed on Resident # 84's bedside table. Failed to ensure two Soiled Utility/Biohazard rooms, were locked. There were 208 residents residing in the facility at the time of survey. The findings Included: During observation 7/29/24 at 08:15 AM Resident #12 was in bed watching television, an open toiletry bag full of razors was on the overbed table, (Photo available). On 07/30/24 at 07:56 AM Resident #12 was in bed awake he revealed the Director of Nursing (DON) took away his bag of razors from him and it has his money in it, he wants the bag back, when Resident #12 was asked if he is allowed to have a bag of razors with him, the resident refused to answer and reported he wanted to see the DON. Interview on 07/31/24 at 08:22 AM Registered Nurse (Staff G) 7-3 PM shift, A wing, stated: This resident does not like anyone to touch his personal items, on Monday, I went in the resident's room and saw the razors on the table, I educated the resident about safety, I told him we have to store the razors and give it back to him when he needs them, the resident got mad, and did not want me to touch his stuff. The resident is allowed to shave himself if he wants but the CNAs (Certified Nursing Assistant) is in the room with the resident during the care time. Once the resident is finished with his care, all the razors are supposed to be taken out of the room and stored in the medication room. Interview on 07/31/24 at 09:29 AM; Assistant Director of Nursing (ADON) stated: The resident is alert and oriented, the resident shaves himself, in the presence of staff, the resident is not allowed to have those razors exposed at the bedside, it is a safety issue for the resident and the other residents in the facility. Moving forward, I spoke to the resident about not being able to have those razors at the bedside with him. Interview on 07/31/24 at 12:03 PM; Certified Nursing Assistant (Staff J),7-3 PM shift, stated: I am assigned to the resident daily, the resident shaves himself sometimes or he would ask me to shave him, I stay in the room with him when he shaves himself and when he is finished with the razor I put it in the sharps container. The razors are kept in the resident's closed drawer in a zipped bag, I never leave the razors with him. Review of the medical records for Resident #12 revealed the resident was admitted to the facility on [DATE]. Clinical diagnoses included but not limited to: Schizophrenia and Major depressive disorder (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Physician's Orders Sheet for July 2024 revealed Resident #12 had orders that included but not limited to: Fluoxetine 10 mg capsule-give 10 mg by mouth one time a day related to major depressive disorder. Risperdal tablet 1 mg (Risperidone)-give 1 mg by mouth two times a day related to other schizophrenia. Record review of Resident # 12's Quarterly Minimum Data Set (MDS) dated [DATE] revealed: Section C for Cognitive Patterns documented Brief interview for Mental Status score 15, on a 0-15 scale indicating the resident is cognitively intact. Section E for behaviors documented no behaviors exhibited. Section N for Medications documented resident is taking antidepressants, antianxiety, antipsychotic, diuretic and hypoglycemic medications. Record review of Resident # 12's Care Plans Dated 06/30/24 revealed: Resident has a self-care deficit and needs staff assistance to perform and complete ADL's secondary to: impaired mobility, has left hemiparesis, weakness Date Initiated: 04/20/2022. Resident will be able to wash and dry face and hands, comb hair and complete upper body dressing with assistance through the next review date. Interventions include- 1/2 bilateral siderail as ordered. Allow resident to perform task at own pace. Break tasks into subtasks to make them easier to follow/complete. Call light in reach and promptly answered. Observe for decline from current function and report if identified. Praise all completed tasks no matter how small. Provide assistance only in the areas difficult for the resident. Allow the resident to do for self as much as possible. Setup needed basic items, washcloth, soap/water, towel, comb, etc. and keep within easy reach daily and as needed. 48906 On 07/29/24 at 9:19 AM Resident #84 was observed awake and alert in bed. A blue shaving razor observed at bedside on side table. No staff present. (photo evidence) Record review of demographic sheet for Resident #84 revealed an admitted [DATE] with diagnosis that included Need for Assistance with Personal Care. Record review of -Quarterly Minimum Data Set (MDS) with reference date 7/10/2024 Section C (Cognitive Status) revealed a Brief Mental Status Score of 14 out of 15 indicated the resident is cognitively intact. Section E (behaviors) revealed behaviors of rejection of care occurred 1 to 3 days. Section GG (Functional Status) revealed Resident #84 required substantial assistance for personal hygiene. Section N (medications) revealed R#84 was taking Diuretic, Antiplatelets, and Hypoglycemic medications. Record review of a Care Plan initiated on 10/3/2023 and started on 7/10/24 revealed Resident #84 was At Risk for Falls with a goal of Resident will not have a significant fall/fall with injury through the next review date. The Interventions included: Anticipate and meet resident's needs as needed and check the environment for clutter or trip hazards, and is well lit, assist and encourage resident to wear well-fitting and non-slip footwear as needed. On 07/29/24 at 9:20 AM Staff Q, Licensed Practical Nurse (LPN) stated: I do rounds when I come on shift. Today when I did my rounds there was no shaving razors at the bedside of [Resident #84]. Staff Q, LPN entered Resident#84's room and removed shaving razor from Resident #84's bedside. Staff Q, LPN further reported the shaving razors are kept in the medication room given to Certified Nursing assistants as needed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106133	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	07/29/24 at 11:15 AM Staff M, Certified Nursing Assistant (CNA) stated: I do rounds and check each resident and make sure there are no medications or objects that can harm the resident in room. I get the shaving razors from the supply room, and I did not bring a shaving razor into the room of [Resident#84] today. On 08/01/24 at 12:51 PM. The Director of Nursing (DON) stated: If residents are alert enough to shave themselves safely they can keep the shaving razors at the bedside. This might affect the safety of any confused resident who may wander onto the room. On 07/30/24 at 9:33 AM Staff L, Certified Nursing assistant (CNA) observed walking in hallway with a tied bag of dirty linens. Staff L, CNA entered The Soiled utility/Biohazard room on the E Nursing wing, without using a code or key. On 07/30/24 at 9:35 AM Staff N, Floor Tech observed entering the Soiled Utility /Biohazard room on the E Nursing wing without using a code or key. On 07/30/24 at 1:07 PM; the Director of Nursing (DON) toured the Soiled Utility/Biohazard room with the surveyor and stated: The doors should be kept locked. The DON opened the Soiled utility/Biohazard room without using a code or key in The E and J wing without a code or key. On 07/30/24 at 1:10 PM Staff N, Floor Tech stated: I entered The Soiled Utility/Biohazard room without entering a code because the door lock isn't working. On 07/30/24 at 1:12 PM Staff L, CNA stated: I entered The Soiled Utility room without entering a code because sometimes the door is left open. On 07/30/24 at 1:15 PM The Environmental Supervisor stated: I fixed the Soiled Utility/Biohazard room door it was unable to be locked due to something being stuck inside the latch. Now staff can use the code to enter. On 07/31/24 at 11:17 AM after a tracheostomy care observation; the Respiratory Therapist was observed carrying the used materials in a tied biohazard bag and entering the Soiled Utility/Biohazard room on The J wing without using a code or key. On 07/31/24 at 12:02 PM, the Respiratory Therapist stated: There is a code for the Soiled Utility Room/Biohazard room but today I opened it without a code without realizing it because usually there is someone inside to open the door for me. On 08/01/24 at 12:54 PM the DON stated: The Soiled Utility Room/Biohazard room door is to be kept locked to ensure safety for our residents. I was not aware that the doors were not locking, we changed the locks. Record review of Policy entitled Regulated (Biohazard) Medical Waste date Implemented 3/2021 Policy: It is the policy of this facility to ensure that regulated medical waste is managed, handled, stored, and transported as per Federal, State and local guidelines and regulations. 16. Storage of regulated medical waste should be under conditions that minimize or prevent foul odors, be well-ventilated, and in accessible to pests. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Reporting Accidents and Hazards dated 3/2020 states: The facility will provide an environment that is free from accidents hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents. This includes: a. Identifying hazards and risks b. evaluating and analyzing hazards and risks c. implementing interventions to reduce hazards and risk d. Monitoring for effectiveness and modifying interventions when necessary

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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. 48906 Based on observations, interviews and record review the facility the failed to ensure medications are secured and properly stored on the facility's E wing and medication at bedside for two (Resident #96 and Resident #98) out of eleven sampled residents as evidenced by the E Nursing unit medication cart was observed unlocked and unattended. Observation of a bottle of nasal spray, eye drops, and Ammonium Lactate Lotion at Resident #96's bedside, a bottle of Ammonium Lactate lotion observed on the side table in front of Resident #98. There were 208 residents residing in the facility at the time of survey. On 07/29/24 at 8:57 AM an observation was made of an unlocked medication cart unattended in The E Nursing unit. (photo evidence) On 07/29/24 at 9:02 AM Staff R, Registered Nurse (RN) exited a resident's room and returned to cart. Approached by surveyor. Staff R, RN stated The medication cart should always be locked when unattended for residents' safety, I left it unlocked because I was not a far distance from the cart. On 07/29/24 at 9:04 AM an observation was made of a bottle of nasal spray, a bottle of eye drops, and a bottle of Ammonium Lactate Lotion at the bedside of Resident#96. (photo evidence) On 07/29/24 at 9:53 AM an observation was made of a bottle of Ammonium Lactate lotion was observed on the side table in front of Resident#98. (photo evidence) On 07/29/24 at 10:32 AM; The Assistant Director of Nursing (ADON) stated: Residents are not allowed to have any medications at the bedside unless it has been ordered by the physician. The ADON was informed that Resident #96 and Resident #98 have medications at the bedside. The ADON stated: [Resident #98 and Resident #96] do not have current orders to keep any medication at the bedside it should administered by staff. I will notify the physician. On 07/29/24 at 10:58 AM Staff Q, Licensed Practical Nurse (LPN) stated: When I did round this morning, I did not observe any medications or lotions at the bedside of [Resident #96]. On 07/29/24 at 11:15 AM Staff L, Certified Nursing Assistant (CNA) stated: I did not see any medications at the bedside for [Resident #96] today. On 07/29/24 at 10:46 AM Staff P, LPN stated: I do rounds when I come shift and check. I look to make sure there are lotions or medications at the bedside to prevent any harm for the resident. The CNAs check daily and if they see any medications in the room unattended, they tell the nurse. On 07/29/24 at 10:52 AM Staff L, CNA: I do rounds when I start my shift to make sure the residents don't have any medications If I see that I report to the nurse. I did not see any lotion on [Resident #98's] side table. (continued on next page)

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	106133	A. Building B. Wing	08/01/2024

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/01/24 at 12:57 PM The Director of Nursing (DON) stated: I assign one staff member daily to clean drawers and remove any things that aren't supposed to be in the drawer. Residents are not allowed to keep any medications at the bedside. DON further stated the medication carts should be locked while unattended. Record review of POLICY titled Labeling of Medications Storage of Drugs and biologicals date implemented: 11/28/2019 revealed policy: It is the policy of this facility to ensure that all medications and biologicals used in the facility will be labeled and stored in accordance with current state, federal, regulations. Storage of Drugs Safe and secure storage (including proper temperature controls, appropriate humidity and light controls, limited access, and mechanisms to minimize loss or diversion) of all medication.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31581 Based on observation, interview and record review, the facility failed to assure that emergency dental services were provided for one (Resident number186) out of one resident who triggered for dental. This practice has the potential to decrease resident's ability to reach their highest potential. The findings included: Record review of the facility's policy titled Dental Services (issued date 3/2021) documented: Policy-It is the policy of the facility to provide Dental Services in accordance to State and Federal regulations; Procedure: 1) The facility will provide from an outside source routine and emergency dental services to meet the needs of each resident and 2) The facility will provide necessary assist the resident by: a) making appointments and b) arranging for transportation to and from the dentist's office. Observation and interview with Resident number 186 on 7/29/24 at 9:55 AM revealed the resident sitting up in bed, watching television with right leg amputee below the knee and missing teeth were noted. The resident stated, I have not seen the dentist since I have been here. I want to see the dentist. Review of the Demographic Face Sheet for Resident number 186 documented the resident was initially admitted on [DATE] with a diagnosis of diabetes mellitus, hypertension, peripheral vascular disease, epilepsy and acquired absence of right leg below knee. Review of the Minimum Data Service (MDS) Quarterly assessment dated [DATE] for Resident number 186 documented the resident's Mental Status (BIMS) Summary Score was 13, indicating no cognitive impairment and able to make her needs known and she required partial to moderate assistance for ADLs (activities daily living) and setup assistance for eating. Review of the Physician's Order Sheets (POS) dated July 2024 and August 2024 for Resident number 186 documented the resident was on a LCS (Low Concentrated Sweets), NAS (No Added Salt), Limited Fat diet, Regular texture and Thin liquids consistency and a dental consult with a diagnosis of toothache (revision date 7/08/2024). Review of the Nutrition care plan (written 1/29/2024) for Resident number 186 documented the following: Focus: Resident is at risk for nutritional and or hydration deficits as evidenced by diabetes mellitus, epilepsy and hypertension; Goal: Resident will show no s/s (signs and symptoms) of dehydration (dry skin, dry cracked lips, concentrated urine, increased confusion, abnormal labs that may indicate dehydration) thru NRD (next review date) x (times) 90D (90 days); Interventions: Diet- LCS, NAS, Limited Fat diet, Regular texture and Thin liquids consistency; Dental consult as needed and oral care daily and PRN (as needed). Review of the electronic health records for Resident number 186 revealed no dental consult was available and the resident did not see the dentist. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/01/24 at 12:01 PM, interview with the Director of Social Services. She stated, She has a dental consult on 12/06/24 at 8:30 AM made by the social services assistant who no longer works here. I don't know when she wrote it. The dental consult was written on a sticky note for the resident. It was not brought to my attention that she had a doctor note on 7/08/24 for a dental consult. She has Medicaid [ ] and not everyone takes it. Observation and interview with Resident number 186 on 8/01/24 at 12:58 PM revealed the resident sitting in a wheelchair in the hallway with right leg amputee below the knee and missing teeth. She stated, I have pain in my tooth. I'm about to ask for something for the pain. On 8/01/24 at 1:12 PM, a subsequent interview with the Director of Social Services. She stated, We called [ ] dental services and she now has a dentist appointment on 8/08/24. I called the ARNP (Advanced Registered Nurse Practitioner) and told him that the resident is in pain and I received medical clearance for the resident for dental extraction. I talked to the resident and she said she was in pain and was going to ask for Tylenol. Review of the Medical Clearance for Dental Extraction form dated 8/01/24 documented the physician gave medical clearance for a dental extraction for Resident number 186. On 8/01/24 at 2:04 PM, interview with Staff S, Licensed Practical Nurse (LPN). He stated, She is alert and oriented times three and able to make her needs known. She requires partial to moderate assistance for ADLs. The physician gave the authorization for the resident to have a dental consult on 7/08/24. The nurse who took the authorization should have forwarded the information to the oncoming nurse. The resident was given Tylenol 500 mg PRN for pain. On 8/01/24 at 2:42 PM, interview and record review of the July POS with the Director of Nursing (DON). He stated, Nobody told me in the morning meeting that she had an order from the doctor for a dental consult on 7/08/24. Yes, she did have an order from the doctor on 7/08/24. Review of the Electronic Medication Administration Record (EMAR) dated August 1, 2024 for Resident number 186 documented the resident received Tylenol 325 mg (milligrams) give 2 tabs (tablets) PO (by mouth) every 6 hours PRN for mild pain with a pain level 3.

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	106133	A. Building B. Wing	08/01/2024

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31581 Based on observation, interview and record review, the facility failed to assure that menus are developed and prepared to meet resident choices including their cultural and ethnic needs for one (Resident number 186) out of one resident who triggered for food. The findings included: Observation and interview with Resident number 186 on 7/29/24 at 9:57 AM revealed the resident sitting up in bed, watching television with right leg amputee below the knee and missing teeth were noted. The resident stated, The food is also lousy. They give us a ham and cheese sandwich on Sundays. Who wants to eat a ham and cheese sandwich on a Sunday. Review of the Demographic Face Sheet for Resident number 186 documented the resident was initially admitted on [DATE] with a diagnosis of diabetes mellitus, hypertension, peripheral vascular disease, epilepsy and acquired absence of right leg below knee. Review of the Minimum Data Service (MDS) Quarterly assessment dated [DATE] for Resident number 186 documented the resident's Mental Status (BIMS) Summary Score was 13, indicating no cognitive impairment and able to make her needs known and she required partial to moderate assistance for ADLs (activities daily living) and setup assistance for eating. Review of the Physician's Order Sheets (POS) dated July 2024 and August 2024 for Resident number 186 documented the resident was on a LCS (Low Concentrated Sweets), NAS (No Added Salt), Limited Fat diet, Regular texture and Thin liquids consistency. Review of the Nutrition care plan (written 1/29/2024) for Resident number 186 documented the following: Focus: Resident is at risk for nutritional and or hydration deficits as evidenced by diabetes mellitus, epilepsy and hypertension; Goal: Resident will show no s/s (signs and symptoms) of dehydration (dry skin, dry cracked lips, concentrated urine, increased confusion, abnormal labs that may indicate dehydration) thru NRD (next review date) x (times) 90D (90 days); Interventions: Diet- LCS, NAS, Limited Fat diet, Regular texture and Thin liquids consistency; Offer meal substitute as needed/requested. Review of the Diet Card for Resident number 186 documented the resident consumed a LCS, NAS, Limited Fat diet, Regular texture with Thin liquid consistency. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Weekly Four Cycle Menu documented the following: 1) Week 1 on Sunday, 6/16/24 residents received at lunch: Hot Roast Beef Sandwich on Hamburger Bun, Baked Potato, Buttered Carrots, Strawberries & Whipped Topping and for dinner: Ham and Cheese Sandwich on Hamburger Bun, Crispy French Fries, Chilled Beets, Gelatin Cubes for dinner; 2) Week 1 on Sunday, 7/14/24 residents received at lunch: Hot Roast Beef Sandwich on Hamburger Bun, Baked Potato, Buttered Carrots, Strawberries & Whipped Topping and for dinner: Ham and Cheese Sandwich on Hamburger Bun, Crispy French Fries, Chilled Beets, Gelatin Cubes for dinner and 3) Week 1 on Sunday, 8/11/24 residents will receive at lunch: Hot Roast Beef Sandwich on Hamburger Bun, Baked Potato, Buttered Carrots, Strawberries & Whipped Topping and for dinner: Ham and Cheese Sandwich on Hamburger Bun, Crispy French Fries, Chilled Beets, Gelatin Cubes for dinner. On 8/01/24 at 8:51 AM, interview and record review with the Dietary Manager. She stated, The residents were complaining about the same food being repeated on the four cycle menus and there were no changes. I have asked for new menus for six months. The residents wanted a change. She confirmed that on Week 1 for Sunday 6/16/24 and 7/14/24 for lunch a hot roast beef sandwich was served on a hamburger bun and a ham and cheese sandwich on a hamburger bun for dinner was served and whenever Week 1 Cycle Menu is used on Sundays the residents will be served a hot roast beef sandwich for lunch on a hamburger bun and a ham and cheese sandwich on a hamburger bun for dinner. Record review of the correspondence between the Dietary Manager and the Registered Dietitian (RD) for an outsourced company that develops the menus for the facility from March 18, 2024 to May 24, 2024 revealed changes were not made to the menu to be implemented. On 8/01/24 at 1:30 PM, interview with the RD, Regional Consultant. She stated, The menu is outsourced. They are approved by a dietitian and were signed by a dietitian on 7/14/24. I am strictly a clinical dietitian. She refused to comment on the menu selections. Review of the Facility Assessment, updated 2/29/2024, date reviewed with QAPI Committee 2/29/2024 documented the facility has a diverse patient population and the Nutrition department provided individualized dietary requirements, liberal diets, specialized diets, tube feeding, cultural or ethnic dietary needs.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 31581 Based on observation, record review and interview the facility failed to ensure food was prepared under sanitary conditions as evidenced by failure to maintain equipment in the nourishment pantry in a clean sanitary manner. This was observed in one of three nourishment pantries and has the potential to affect thirty-five out of forty residents who eat orally residing on the J unit in the facility at the time of the survey. The findings include: Record review of the facility's policy titled Safety Awareness (issued date 3/2021) documented: Policy-It is the policy of the facility to provide Safety Awareness in accordance to State and Federal regulations; Procedure: 2) The facility will maintain all essential mechanical, electrical and patient care equipment in safe operating condition. Observation of the J Unit Floor Nourishment Pantry Room on 7/30/24 at 11:31 AM with Staff S, Licensed Practical Nurse (LPN) revealed the following: Microwave used to warm up resident's foods was not clean, had brown, dried substances and contained brown-like rust stains in the microwave. Photographic evidence submitted. On 7/30/24 at 11:33 AM, interview with Staff S, LPN confirmed the microwave contained brown like rust stains in the microwave. On 7/31/24 at 8:36 AM, interview with the DON confirmed the microwave contained brown like rust stains in the microwave and would be replaced.

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	106133	A. Building B. Wing	08/01/2024

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 45019 Based on observations, interview and record review, the facility's quality assurance and assessment committee (QAA) failed to demonstrate effective plan of actions were implemented to correct identified quality deficiencies in the problem areas related to repeated deficient practices; as evidenced by, review of the facility's history revealed during the survey with exit dated 03/24/2023 the facility was cited for these repeated deficiencies identified during this survey with exit dated 08/01/24 related to: F584 Safe/ Clean/ Comfortable/ Homelike Environment, F641 Accuracy of Assessments, F645 PASRR Screening for Mental Disorder/ Intellectual Disability, F656 Develop/implement comprehensive care plan, F684 Quality of Care, F791 Routine/Emergency Dental Services, F761 Label/Store Drugs & Biologicals and F867 QAPI/QAA Improvement Activities. This pattern of repeated deficient practice has the potential to affect any of the 208 residents residing in the facility at the time of the survey. The findings included: Review of the Quality Assurance and Performance Improvement (QAPI) Committee Meeting Sign-in Sheets dated 5/29/24,6/12/24, and 7/9/24 documented the facility had a QAA Committee meetings monthly. Attendees included: Administrator, Medical Director, Director of Nursing (DON), Assistant Director of Nursing (ADON), Infection Control Preventionist/Risk Manager, Dietary Manager, Clinical Dietician, Director of Housekeeping, Director of Maintenance, Director of therapy, Director of Human resources, Director of admissions, Director of Business office, Director of Social Services, Director of Activities, MDS (Minimum Data Set) Coordinator, and Consultant Pharmacist. Interview on 7/26/24 at 9:34 AM with the Director of Nursing/Quality Assurance (QA), Administrator/QA; revealed: The QAA Committee meets every month on the second Thursday of the month, the last meeting was held on 07/09/24. The committee consists of the Medical Director, Administrator, DON, Assistant Director of Nursing (ADON), corporate staff, pharmacy representative and all interdisciplinary team members. The focus of QA committee is to review all the departmental reports, anything we notice that is wrong, review how we fix the issues and what to do to improve. We do audits and discuss the interventions at the next meeting to see how well what we put in place is working. Record review of the facility policy and procedure titled Quality Assurance Performance Improvement (QAPI), implemented June 2021 indicates: 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: 11. Governance and Leadership a) The governing body and/or executive leadership is responsible and accountable for the QAPI program. b) Governing oversight responsibilities include, but are not limited to the following: (continued on next page)

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	106133	A. Building B. Wing	08/01/2024

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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	I. Approving the QAPI plan annually, and as needed. II. Ensuring the program is ongoing, defined, implemented, maintained and addresses identified concerns. III. Ensuring the program is sustained during transitions in leadership and staffing. IV. Ensuring the program is adequately resourced, including ensuring staff time, equipment, and technical training as needed. V. Ensuring the program identifies and prioritizes problems and opportunities that reflect organizational processes, functions, and services provided to residents based on performance indicator data and resident and staff input, and other information. VI. Ensuring that corrective actions address gaps in systems and are evaluated for effectiveness. VII. Setting clear expectations around safety, quality, rights, choice and respect. c) The QAA Committee shall communicate its activities and the progress of its subcommittee PIPs to the governing body (if leadership role is greater than the administrator) at least quarterly, with a formal meeting no less than annually. d) The QAA Committee shall submit supporting documentation of ongoing QAPI activities to the governing body upon request. e) QAPI training that outlines and informs staff of the elements of QAPI and goals of the facility will be mandatory for all staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106133	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Dade Nursing and Rehabilitation Center	1255 NE 135th Street North Miami, FL 33161

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 31581 Based on observation, interview and record review, the facility failed to ensure a microwave used for residents was in good repair. The microwave in the Nourishment Pantry Room contained brown-like rust stains. This has the potential to affect thirty-five out of forty residents who eat orally residing on the J unit in the facility at the time of the survey. The findings included: Record review of the facility's policy titled Safety Awareness (issued date 3/2021) documented: Policy-It is the policy of the facility to provide Safety Awareness in accordance to State and Federal regulations; Procedure: 2) The facility will maintain all essential mechanical, electrical and patient care equipment in safe operating condition. Observation of the J Unit Floor Nourishment Pantry Room on 7/30/24 at 11:31 AM with Staff S, Licensed Practical Nurse (LPN) revealed the following: Microwave used to warm up resident's foods was not clean, had brown, dried substances and contained brown-like rust stains in the microwave. Photographic evidence submitted. On 7/30/24 at 11:33 AM, interview with Staff S, LPN confirmed the microwave contained brown like rust stains in the microwave. On 7/31/24 at 8:36 AM, interview with the DON confirmed the microwave contained brown like rust stains in the microwave and would be replaced.