

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

Printed: 07/18/2026
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 01/28/2026
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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to maintain a safe, clean, sanitary, homelike environment in one (J hallway) out of three nursing stations with trash bins left open and unattended, residents' rooms and floor surfaces were soiled and had foul odors, overflowing trash, visible debris, unflushed toilets, dirty furnishings, soiled torn linen and unrepaired structural damage in multiple resident rooms. There were 210 residents in the facility at the time of the survey The findings included: Observation on 01/25/26 at 6:18 AM, revealed three uncovered trash bins with trash left unattended in the J hallway. (photo evidence) On 01/25/26 at 6:28 AM Staff M, Floor Tech stated, I left the carts in the hallway. The protocol is to take the carts outside to the dumpster one by one to avoid leaving trash in hallway and keep the bins covered for infection control. On 01/25/2026 at 07:58 AM, room [ROOM NUMBER]C was observed to have a brown-colored substance splashed on the wall. The floor surface was sticky. The trash bin was overflowing with trash. On 01/25/2026 at 08:11 AM, room [ROOM NUMBER]C was observed to have a sticky floor surface with black dust-like debris present. A foul odor was noted in the room. On 01/25/2026 at 08:39 AM, room [ROOM NUMBER]B was observed to have trash overflowing from the bins. A foul odor was present inside the room. On 01/25/2026 at 08:51 AM, room [ROOM NUMBER]B was observed to have black dust-like debris on the floor. The toilet seat had a yellow stain. The bathroom floor surface was sticky, and pieces of paper were present on the floor. On 01/25/2026 at 10:13 AM, room [ROOM NUMBER]B was observed to have a liquid resembling urine on the floor. A foul odor was present. On 01/25/2026 at 10:15 AM, room [ROOM NUMBER]B was observed to have feces-like material inside the toilet that had not been flushed. On 01/26/2025 at 10:41 AM room [ROOM NUMBER]B had feces-like material dripping from the toilet seat to the inside of the toilet. (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 01/25/2026 09:22 AM, room [ROOM NUMBER]B noted the floor surface was sticky with black dust/dirt-like debris and scattered paper on it and cups under one of the beds. The side tables were visibly dirty and sticky to touch. The toilet contained feces-like material and had not been flushed. There wall behind the toilet had a broken tile and a hole. Observation 01/25/2026 at 09:24 AM, revealed Resident #113's linens had a hole, visible stains and had a foul odor. On 01/26/2026 at 10:36 AM, Resident #113 was observed to have visible stains and a hole on his linens. The linens had a foul odor. Review of Resident #113's clinical records revealed the resident was readmitted on [DATE], with an initial admission date of 06/22/2022. Clinical diagnoses included schizophrenia and major depressive disorder. The Quarterly Minimum Data Set (MDS) dated [DATE] cognitive section documented intact cognition. The MDS further indicated that the resident requires setup and cleanup assistance with eating, oral hygiene, and toileting hygiene, and requires supervision or touching assistance with bathing, dressing, footwear, and personal hygiene. The resident's care plan identifies a self-care deficit requiring staff assistance with activities of daily living and includes interventions to provide setup of basic hygiene items, ensure items are kept within easy reach, and provide assistance as needed. During an interview on 01/27/2026 at 11:44 AM with Staff U, Housekeeping Aide was asked how often garbage in the bathroom is changed and rooms cleaned; translation assistance had to be provided by the surveyor because Staff U, Housekeeping Aide noted she does not speak English revealed she works the 7:00 AM to 3:00 PM shift, checks rooms three times daily and cleans the rooms once per day with water and the facility-approved detergent for cleaning and indicated that when floors are sticky, the rooms are waxed. Interview on 01/27/2026 at 12:12:01 PM, the Housekeeping Director revealed housekeeping prioritizes rooms identified as requiring more attention, including rooms with odors, food, or garbage accumulation. November 15, 2025, was the last time floors were waxed and that housekeeping planned to wax the rooms again on the following Monday. Floors are buffed daily after breakfast. When asked specifically about the stickiness reported in room [ROOM NUMBER]B, he stated that the room requires frequent attention, and no one had reported stickiness and the wax used is not sticky. Interview on 01/27/2026 at 12:35 PM, the Director of Maintenance was asked about the identified concerns, he revealed rooms requiring repair are tracked daily, maintenance staff work Monday through Thursday, with three staff members assigned from 7:00 AM to 3:00 PM and tiles are checked weekly. On 01/28/2026 at 3:35 PM the Infection Preventionist revealed that Resident #113 does not want anyone entering the room for cleaning. The Infection Preventionist revealed that while the room is considered the resident's home, leaving the room uncleaned may present safety concerns, and that changes in hygiene or refusal of cleaning may indicate potential underlying medical conditions. On 01/28/2026 at 3:47 PM an interview with the Director of Nursing (DON) revealed that soiled or damaged linen are required to be removed and sent to the laundry and are evaluated by housekeeping (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for disposal if necessary. Some residents refuse linen changes or removal of items from their rooms. The residents' rooms and bathrooms are cleaned daily. Staff provide education to residents but cannot force compliance when residents refuse cleaning, specifically referencing rooms requiring additional attention. Rooms identified as needing more attention are visited more frequently by housekeeping staff and the Housekeeping Director is responsible for ensuring compliance with environmental cleanliness and linen standards.		

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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. Based on observations, record review and interviews the facility's Quality Assessment and Assurance (QAA)/QAPI committee demonstrate effective plan of action were implemented to correct identified quality deficiency in problem areas related to repeated deficient practice for F761-Lable/Store Drugs and Biologicals, F684-Quality of Care, F689-Free of Accident Hazards/Supervision/Devices and F867-QAPI/QAA Improvement Activities. As evidenced by: F761, F684, F689 and F867 were cited during a recertification survey ending 09/04/2024. There were 210 residents residing in the facility at the time of the survey. The findings included: Record review of the facility's survey history revealed, during recertification conducted on September 01, 2024, through September 04, 2024, F761-Lable/Store Drugs and Biologicals, F684-Quality of Care, F689-Free of Accident Hazards/Supervision/Devices and F867-QAPI/QAA Improvement Activities. Review of the facility's policy and procedure titled Quality Assurance & Performance Improvement (QAPI) 06/10/2021 stated Policy: 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. Interview on 01/28/2026 at 03:12 PM with the Administrator and Director of Nursing (DON) revealed: The QAPI/QAA team is composed of the Administrator, DON, Assistant Director of Nursing (ADON), Medical Director or attending physician, and members of the management team. Additional participants, include department heads and nursing unit staff are invited to participate as needed. The QAPI/QAA committee meets on the third Tuesday of every month. The primary purpose of the committee is to ensure regulatory compliance by identifying deficiencies, determining root causes, implementing corrective interventions, and monitoring outcomes to achieve and sustain compliance. The committee becomes aware of issues through strong interdepartmental communication, daily morning clinical meetings, and review of dashboard data. When concerns are identified, related issues are also reviewed, discussed during QAPI meetings, and addressed through Ad Hoc meetings when immediate action is required. Issues are prioritized based on severity and the potential risk for regulatory noncompliance, with higher-risk concerns addressed promptly. Corrective actions are communicated to staff, and leadership verifies implementation through ongoing feedback and staff-reported observations. Improvement is determined through audit results, staff and management feedback, visible practice changes, and evidence of sustained progress over time.		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observations, interviews and record review, the facility failed to secure confidential information for residents on two (East and J) out of three nursing stations as evidenced by: 1) Paperwork with residents' medical information left visible and unattended at the J nursing station. 2) An unattended computer screen with resident information visible on the East nursing station. There were 210 residents residing in the facility at the time of survey. The findings included: 1) Observation on 01/25/2026 at 6:33 AM, revealed unattended medical information with residents' names at the J nursing station. On 01/25/2026 at 6:45 AM, Staff A, Overnight Supervisor Registered Nurse was apprised of the identified concern and stated, That posting is a privacy violation and will be removed. All information is to be kept private. The findings include: 1) On 01/27/2026 at 09:45 AM a staff member left the computer unattended at the East wing nursing station with a patients' information visible. Interview on 01/27/2026 at 12:32 PM with Staff V, LPN stated I have been a nurse supervisor for one year and work throughout all units in the facility. My understanding of Health Insurance Portability and Accountability Act (HIPAA) focuses on maintaining resident privacy and confidentiality. Examples include ensuring computer screens and medication carts are locked before stepping away and safeguarding all resident information from unauthorized access or disclosure. I consistently reinforce HIPAA education with staff during daily interactions; however, formal in-service training is primarily provided by the infection preventionist. HIPAA training is reinforced during daily morning huddles, with more in-depth discussions and updates conducted during weekly staff meetings. Interview on 01/28/2026 at 03:53 PM with Director of Nursing (DON) stated Regarding HIPAA, my understanding is that patient privacy and confidentiality must be maintained at all times. Computer screens must be closed or locked when not in use, and patient information at nursing stations should not be visible to unauthorized individuals. Staff should avoid discussing patient information aloud in public areas. Medication carts must remain closed, and computer screens should be locked before walking away. Staff are not permitted to leave computers unattended while logged in. Education and reinforcement of HIPAA and privacy practices are a collaborative effort between myself and the infection preventionist through ongoing training and in-service sessions. Review of the facility policy titled HIPPA Policy 11/27/2019 stated 1. Examples of violations include, but are not limited to:e. Leaving a secured application unattended while logged on.		

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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** Based on observations, interviews, and record review facility created an unsafe environment with potential accidents and hazards for one (Resident#94) out of two sampled smoking residents and all residents as evidenced by: 1) The facility's staff failed to provide an apron for Resident#94 while smoking. 2) Facility staff failed to remain vigilant while assigned to monitor to prevent elopement. 3) Facility staff failed to keep one out of six housekeeping carts locked while unattended. This deficient practice increased the risk of accidents and hazards that could have caused serious harm or injuries. There were seven residents listed as smokers on the J Unit and six housekeeping carts. The findings included: 1)Observation on 01/25/26 at 6:00 AM, Staff L, Monitor seated in a chair with head down and eyes closed near double doors at the end of The J hallway. Surveyor greeted Staff L, Monitor twice and staff did not move or respond. Surveyor greeted Staff L, Monitor again and Staff L, Monitor looked up. Interview on 01/25/26 at 6:05 AM, Staff L, Monitor stated, I am assigned to monitor during night shift to ensure residents don't elope through the double doors. Surveyor asked Staff L, Monitor How can residents be properly monitored while Staff L, Monitor is seated with eyes closed and head down and Staff L, Monitor replied, Sorry. On 01/25/26 at 8:10 AM Staff E, Registered Nurse (RN) was notified about identified concern stated, I monitor staff and they know what they are supposed to be doing. During an interview on 01/28/26 at 10:42 AM The Assistant Director of Nursing (ADON) revealed there is a monitor assigned overnight at the double doors in the J hallway to prevent residents from exiting the building. Further revealed the monitors are expected to sit by the door and remain awake. 2)Observation on 01/25/2026 at 6:52 AM, revealed a housekeeping cart with keys in the door. (photo evidence) On 01/25/2026 at 6:55 AM, Staff N, Housekeeping staff returned to cart and was notified about identified concern and stated, Sorry. I am supposed to keep the cart locked and the keys with me. During an interview on 01/28/2026 at 11:25 AM, The Housekeeping Director stated, The housekeeping carts should be locked when unattended and the keys are to be kept with housekeeping staff. 3. Observation on 01/28/26 at 9:30 AM, revealed Resident#94 smoking with no apron. Resident#94 was unable to verbalize answers to any questions. On 01/28/26 at 9:35 AM Staff J, Driver/ Monitor was asked by surveyor which residents require aprons stated, Residents listed dependent with apron. Record review of the smoking list kept in the smoking area revealed Resident#94 was listed as dependent and did not include apron.(photo evidence) Record review of a demographic sheet revealed Resident#94 was admitted on [DATE] and readmitted on [DATE] with diagnosis that include but not limited to: Metabolic Encephalopathy. Record review of an admission Minimum Data Set (MDS) reference dated 12/13/24 revealed Resident#94's Brief Interview for Mental Status was undetermined and used Tobacco. Record review of a care plan initiated on: 12/24/24 and revised on: 10/01/25 revealed Resident#94 was at risk for injury such as burn from cigarettes related to smoking practices, a dependent smoker, and is provided an apron with an interventions to: Provide smoking apron as needed. Record review of September and December 2025 Smoking Screens indicated Resident#94 required a smoking apron. Interview on 1/28/26 at 10:05 AM, The Social Services assistant was interviewed about the smoking screen completed in September and stated, Both smoking assessments for Resident#94 were incorrect. I don't know why the care plan was not updated. Also revealed the December smoking screen was completed by another staff member. During an interview on 01/28/26 at 11:06 AM, The Social Services Director stated, The care plans and screenings for Resident#94 are correct. The list kept outside in the smoking area was not updated correctly. The list will be updated. Record review of facility policy titled Smoking Policy no date revealed Policy: This facility shall establish and maintain safe resident smoking practices. Record review of facility policy titled Accidents and Supervision date implemented: 11/27/2017 Reviewed/Revised on 01/16/2019 revealed Policy: The resident environment remains as free of (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	accident hazards as is possible; and each resident receives adequate supervision and assistive devices to prevent accidents. This includes:Identifying hazard(s) and risk(s)Evaluating and analyzing hazard(s) and risk(s)Implementing interventions to reduce hazard(s) and risk(s)Monitoring for effectiveness and modifying interventions when necessary		

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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, the facility failed to properly position an indwelling urinary catheter tubing and drainage bags for two (Resident # 7 and Resident # 93) out of three sampled residents with an indwelling urinary catheter. Resident # 7's urinary catheter drainage bag was observed on the floor uncovered and drainage bag was on the floor, Resident #93's indwelling catheter tubing lay over the right-side bedside rail padding above the bladder, which prevented the flow of urine from the bladder and the drainage bag was in a privacy bag that touched the floor. These deficient practices increased the residents' risk for catheter-associated urinary tract infections and other serious medical issues. At the time of this survey, thirteen residents with indwelling urinary catheters resided in the facility. The findings include: Resident #7 Observation on 01/25/2026 at 6:33 AM revealed Resident #7 in bed the indwelling urinary catheter drainage bag was uncovered on the floor, the privacy bag was also noted on the floor. The resident reported that he had had the indwelling catheter for one week and did not know why the catheter bag was on the floor. (Photographic evidence). On 01/28/2026 at 6:00 AM, Resident #7 was observed in bed with eyes closed. The indwelling urinary catheter drainage noted in a privacy bag and touching the floor (Photographic evidence). Record review of Resident #7 clinical records revealed a re-admission to the facility on [DATE] and had an indwelling urinary catheter in place related to diagnosis of pressure ulcer of the sacral region, unstageable. Record review of Resident #7's physician orders revealed indwelling urinary catheter related orders dated 1/1/2026: Provide catheter care every shift and as needed. Monitor catheter every shift for signs and symptoms of infection or blockage. Check catheter stabilization device every shift and as needed. Cover the catheter drainage bag at all times Review of the Resident #7's Quarterly Minimum Data Set (MDS) dated [DATE] indicated the resident did not have a catheter at that time and was participating in a bladder toileting program. Review of the resident #7's care plan (review start date 2/6/2026, completion date 1/21/2026) revealed: The resident has an indwelling urinary catheter and is at risk for urinary tract infection and other catheter-related complications. Interventions included: Ensure the catheter is attached to bedside drainage and that a closed drainage system remains intact, place the drainage bag in a privacy bag at all times, provide indwelling catheter care per facility protocol. Interview on 01/25/2026 at 06:43 AM Staff O, License practical nurse (LPN) revealed the indwelling catheter drainage bag should not be on the floor, indwelling catheter drainage bags are supposed to be attached to the side of the bed and should be covered. Interview on 01/25/2026 at 08:01AM, Staff P, Registered Nurse (RN) revealed she was the nurse assigned to Resident #7 the last time she observed Resident #7, the catheter drainage bag was anchored to the side of the bed inside a dignity (privacy) bag furthermore the resident had no history (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of removing the catheter or drainage bag. When shown photographic evidence Staff P, RN noted the placement of the catheter drainage not acceptable. Resident #93 Observation on 01/25/2026 at 1:39 PM, Resident #93 was awake in bed, the indwelling urinary catheter tubing contained dark red urine and positioned over the right-side bed rail padding and the drainage bag noted in a privacy bag was touching the floor (Photographic evidence). Observation on 01/26/2026 at 1:26 PM, revealed Resident # 93's indwelling urinary catheter tubing and dignity bag were touching the floor next to the bed. On 01/26/2026 at 2:04 PM, Staff D, Registered Nurse (RN) was made aware of the identified concern and stated, It should not be touching the floor for infection control. Record review of a demographic sheet revealed Resident # 93 was admitted on [DATE] and readmitted on [DATE] with diagnosis that include but not limited to: Gastrostomy status and pressure ulcer of sacral region. Record review of a quarterly Minimum Data Set (MDS) reference dated 11/21/25 revealed Resident # 93 Brief Interview of Mental Status (BIMS) score was undetermined, was dependent on all Activities of Daily Living had an indwelling catheter and a feeding tube. Record review of a care plan initiated on 10/16/2025 and revised on 12/04/2025 revealed Resident # 93 had an indwelling catheter and was at risk for Urinary Tract Infection (UTI) and other catheter related problems with an intervention to attach catheter to bedside drainage and ensure closed drainage system intact. Interview on 01/28/2026 at 10:40 AM, The Assistant Director of Nursing stated, The facility's protocol for caring for residents with an indwelling urinary catheter include ensuring tubing is not kinked and preventing tubing and bag from touching the floor to prevent infection. On 01/28/2026 at 11:31 AM an interview with Infection preventionist and Director of nursing revealed that an indwelling catheter drainage bag should not be placed on the floor and should be maintained inside a privacy bag. Interview on 01/28/2026 at 12:46 PM Staff Q, Certified Nurse Assistant (CNA) revealed an indwelling catheter drainage bag should not be placed on the floor and should be inside a privacy bag. Interview on 01/28/2026 at 12:55 PM Staff R, Certified Nurse Assistant (CNA) stated the urine collection bag should covered with a privacy bag and should not be touching the floor. On 01/28/2026 at 1:40 PM the photographic evidence of Resident #93's catheter tubing placement identified on 01/25/2026 was shown to the Infection Control Preventionist (ICP). The ICP acknowledged the concern and revealed the tubing should be below the bladder to prevent backflow which could cause a Urinary Tract Infection. Review of the policy titled Infection Control issued on 06/2020 revealed that it is the policy of the facility to ensure that the Infection Control Program is designed to prevent, identify, report, (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations records reviewed and interviews, the facility's staff failed to follow medication administration procedure via Percutaneous Endoscopic Gastrostomy tube (PEG) in accordance with professional standards for one of one resident (Resident # 93) observed for medication administration via PEG tube; as evidenced by staff did not clean the tip (port) and did not check the PEG tube for placement and patency before medication administration. This deficient practice can lead to severe, life-threatening complications for Resident #93. There were 19 residents with PEG tubes residing in the facility at the time of the survey. The findings included: Observation on 01/25/2026 at 1:29 PM of medication administration performed by Staff F, Licensed Practical Nurse (LPN) for Resident # 93 revealed Staff F, LPN verified the physician's orders in the Electronic Health Records performed hand hygiene using hand sanitizer and prepared two (2) Bromocriptine 2.5 milligrams (ml) tablets, crushed and placed the medication in a 30 ml (milliliter) cup and added water to dissolve the medication. Staff F, LPN entered Resident #93's room, provided privacy, explained procedure being performed to Resident # 93, placed tray with dissolved medication, cup with water and syringe on the overbed table, adjusted the bed height, performed hand hygiene using hand sanitizer and applied gloves. It was noted that the resident's enteral feeding pump was off and tubing disconnected and Staff F, LPN revealed the feeding was off because the resident had episodes of vomiting earlier in the morning. Staff F, LPN proceeded to open the peg tube valve port inserted the syringe, poured water in syringe but the water was not flowing; Staff F, LPN was noted squeezing and sliding her fingers along the tube to clear the tubing, but the water still was not flowing. Staff F, LPN then pushed the plunger into the syringe and pushed the water in, removed the plunger, poured the dissolved medication into the syringe but the contents in the syringe was not flowing freely. Staff F, LPN pushed the contents with the syringe's plunger removed plunger and added 30 ml water and pushed in the water with the plunger; removed the syringe and connected the tubing to the feeding pump. Staff F, LPN did not check the PEG tube placement, did not clean the valve port before administering the medications and did not clean the connector tip before connecting the feeding pump. Clinical records revealed Resident #93 was admitted to the facility on [DATE]. Clinical diagnoses include but not limited to: Aphasia following Cerebral Infarction, Dysphagia following Cerebral Infarction, Gastrostomy Status, Seizures, Parkinsonism, Respiratory Failure and Tracheostomy Status. Review of Resident # 93's Physician Order Summary Report for January 2026 included order dated 01/22/2026: Enteral Feed Order every shift Check peg tube for placement and patency every shift. Order dated 12/02/2025: Enteral Feed Order- every shift Flush Peg Tube With 30 ml of water Before and After Meds Administration Order dated 12/02/2025: Enteral Feed Order- every shift [formula] 1.5 Continuous Feeding at 55 ml/hr. (milliliters per hour) x 22 hrs. for a total of 1,210 ml infused; on at 12:00 PM, off at 10:00 AM. Bromocriptine Mesylate oral tablet 2.5 mg. Give 2 tablet via PEG-Tube every 6 hours related to other secondary Parkinsonism. Review of Resident # 93's care plan initiated 05/16/2025, Revision on: 07/24/2025 Target Date: 11/19/2025 revealed: Focus- Resident #93 is enterally fed and is at risk for complications related to: tube feeding. Goal- will remain free of complications of tube feeding such as dehydration, nausea, vomiting, diarrhea, aspiration; signs /symptoms of infection and dislodgement over the next review date. Interventions- Check for tube placement and residual volume. Check patency and placement of peg tube every shift. Review of the resident's Quarterly Minimum Data Set (MDS) reference dated 11/21/25 revealed Resident # 93 Brief Interview of Mental Status (BIMS) score was undetermined, was dependent for all Activities of Daily Living and has a feeding tube. During an interview on 01/25/2026 at 2:25 PM with Staff F, LPN the identified concerns were discussed including the facility's protocol for administering medications via PEG. Staff F, LPN stated: I missed steps and did not check the tube placement; I only checked for tenderness and distention (continued on next page)		

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

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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 01/28/2026
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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with my hands.During an interview on 01/28/2026 at 1:30 PM, the Director of Nursing (DON) and the Infection Control Preventionist (ICP) were apprised of the identified concerns. The ICP and DON explained that staff are expected to clean tip and valve connector before use and check the PEG tube placement before administering medications. Review of the facility's policy titled Medication Administration via Enteral Tube; Implemented 2020 indicated:Policy:It is the policy of this facility to ensure the safe and effective administration of medications via enteral feeding tubes by utilizing best practice guidelines.10. Procedure:h. Enteral tube placement must be verified prior to administering any fluids or medication.		

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 01/28/2026
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observations, records review and interviews, the facility failed to provide adequate respiratory care and services for one (Resident #1) out of two sampled tracheostomy residents as evidenced by an observation of oxygen being delivered at a rate below the prescribed level for Resident #1. There were seven residents with a tracheostomy residing in the facility at the time of survey. The findings include. During a Tracheostomy (trach) care observation on 01/27/26 at 11:14 AM Resident #1's oxygen was in progress at a rate of four Liters per minute (L/min) (photo evidence). Surveyor notified Staff I, Respiratory Therapist (RT) and Staff I, RT revealed the order is for five (5) L/min. Staff I, RT then adjusted the oxygen concentrator to prescribed rate. On 01/27/2026 at 11:57 AM Staff D, Registered Nurse (RN) stated: The order for oxygen is 5 L/min. I do rounds frequently. This morning when I came on shift it was at 5 L/min. On 01/27/2026 at 12:19 PM Staff H, Certified Nursing Assistant (CNA) stated, I never touch residents' oxygen machines, that is not my responsibility. Record review of a demographic sheet revealed Resident #1 had an admission date of 11/20/2025 with diagnosis that included: Tracheostomy and Acute and Chronic Respiratory failure with hypoxia. Record review of a Quarterly Minimum data Set (MDS) reference dated 12/5/25 revealed Resident #1's Brief interview of mental status score was undetermined, dependent for all activities of daily living, received oxygen therapy, suctioning, and trach care. Record review of a care plan initiated on 07/29/2025 and revised on 07/29/2025 revealed Resident #1 had a tracheostomy and interventions that included: administer medication and or oxygen as ordered. Record review of a physician's order sheet revealed Resident #1 had an order dated 1/15/26 directions: Trach: Oxygen 5L/Min continuous via trach collar, humidified (Concentrator with compressor) Maintain oxygen saturation over 92% every shift Record review of a policy titled, Tracheostomy Care dated 3/2020 reviewed 8/2024 revealed Policy: The facility will ensure that residents who need respiratory care, including tracheostomy care and tracheal suctioning, is provided such care consistent with professional standards of practice, the comprehensive person-centered care plan and resident goals and preferences. Record review of a policy titled, Physician Services date: 3/1/2021 revealed intent: It is the policy of the facility to ensure Physician Services are in accordance with State and Federal regulations. Procedure: 6. All physician orders must be followed as prescribed, and if not followed, the reason must be recorded on the resident's medical record during that shift.		

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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	
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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 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. Based on observations records reviewed and interviews the facility failed to ensure drugs and biologicals are securely stored in accordance with professional standards for one (J Wing Cart 2) out of four medication carts reviewed as evidenced by medication cart two on the J wing was noted unlocked and unattended 2) Facility staff left medications unattended at bedside for Resident #50. The findings included: Observation on 01/25/2026 at 6:35 AM, revealed medication inside a transparent cup left unattended on the side table next to Resident # 50. (photo evidence)1) On 01/25/2026 6:38 AM Staff B, Registered Nurse (RN) entered the room and was asked by surveyor if medication can be left at the bedside unattended. Staff B, RN replied, I left the medication to get a gown. Further stated, Medications are stored in the medication cart to protect residents.2) Observation on 01/26/2026 at 9:38 AM, an unlocked, unattended medication cart (photo evidence). On 01/26/2026 at 9:43 AM Staff D, RN exited a room and was asked about the unlocked cart and stated, I left it open because I was helping a resident and was not far from the cart. We are supposed to keep the medication cart locked when away from the cart. During an interview on 01/28/2026 at 10:43 AM, The Assistant Director of Nursing stated, Medications are to be stored in a secure locked cart or medication room for safety of residents. Record review of facility's policy and procedure titled Labeling of Medications Storage of Drugs and Biologicals issued 3/2020 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.		