Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	111335	A. BUILDING: _____ B. WING _____	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINES NURSING HOME	301 NE 141 STREET MIAMI, FL 33161

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	INITIAL COMMENTS A re-licensure survey was conducted at Pines Nursing Home on , , through , , . Deficiencies were identified at the time of the survey	N 000		
N 202	400.022(1)(m), FS Right to Privacy (m) The right to have privacy in treatment and in caring for personal needs; to close room doors and to have facility personnel knock before entering the room, except in the case of an emergency or unless medically contraindicated; and to security in storing and using personal possessions. Privacy of the resident's body shall be maintained during, but not limited to, toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. Residents' personal and medical records shall be confidential and exempt from the provisions of s. 119.07(1). This Statute or Rule is not met as evidenced by: Based on observations record review and interview, the facility failed to safeguard and ensure privacy of residents' confidential Electronic Health Records (EHR); as evidenced by one out of two of the facility's medication carts' computer screen was left unlocked and unattended and a physical note posted on two of two medication carts revealing residents' information. There were 44 residents residing in the facility at the time of the survey. The findings include: On at 08:51 AM during an observation of the facility, a note pertaining to Resident #23's authorized visitors and what steps to follow was	N 202		

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N 202	Continued From page 1 observed posted on Medication Cart A and Medication Cart B computer screens (Photo evidence). On at 09:15 AM during medication administration observation the Electronic Medication Administration Records (EMAR) on the computer screen for Medication Cart A was left unlocked and unattended with a resident's EMAR information visible (Photo evidence). Interview on at 09:45 AM Registered Nurse (Staff B) stated: "Yes I forgot to lock the computer before going to administer medications to the resident, it was a mistake, I know I am supposed to lock the computer screen when I am not with the medication cart." Interview on at 07:54 AM Director of nursing (DON) revealed the signs were posted on the computers regarding Resident # 23 to make sure all staff, including the as needed (PRN) nursing staff were aware of visitor restrictions for Resident # 23. The signs were supposed to be flipped backwards to the empty side and not displaying residents' information. The brother's behavior is an issue, every time he visits, he refuses to leave the facility. The police had been called several times about the brother, when he takes his brother out on pass, he never brings him to the facility on time and is very combative and unruly to staff. Review of the undated facility policy and procedure titled Resident Rights - Personal Privacy/Confidentiality of Records indicate: It is the policy of the facility to provide the resident and or legal representative personal privacy and confidentiality of records in such a manner to	N 202		

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N 202	Continued From page 2 acknowledge and respect resident rights. Class III	N 202		

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F 000	INITIAL COMMENTS A recertification survey was conducted at Pines Nursing Home on , through , . The facility was not in compliance with 42 CFR 483, Requirements for Long Term Care Facilities.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(i) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the	F 583		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		/2025

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.

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F 583	Continued From page 1	F 583		

Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.
This REQUIREMENT is not met as evidenced by:
Based on observations record review and interview, the facility failed to safeguard and ensure privacy of residents' confidential Electronic Health Records (EHR); as evidenced by one out of two of the facility's medication carts' computer screen was left unlocked and unattended and a physical note posted on two of two medication carts revealing residents' information. There were 44 residents residing in the facility at the time of the survey.

The findings include:

On at 08:51 AM during an observational of the facility, a note pertaining to Resident #23's allowed visitors and what steps to follow (Photo evidence) was observed posted on Medication Cart A and Medication Cart B computer screens.

On at 09:15 AM during medication administration observation the Electronic Medication Administration Records (EMAR) screen on the computer on Medication Cart A was left unlocked and unattended with a resident's EMAR information visible (Photo evidence).

Interview on at 09:45 AM Registered Nurse (Staff B) stated: "Yes I forgot to lock the computer before going to administer medications to the resident, it was a mistake, I know I am supposed to lock the computer screen when I am not with the medication cart."

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F 583	Continued From page 2 Interview on at 07:54 AM Director of nursing (DON) revealed the signs were posted on the computers regarding Resident #23 to make sure all staff, including the as needed (PRN) nursing staff were aware of visitor restrictions for Resident # 23. The signs were supposed to be flipped backwards to the empty side and not displaying residents' information. The brother's behavior is an issue, every time he visits, he refuses to leave the facility. The police had been called several times about the brother, when he takes his brother out on pass, he never brings him to the facility on time and is very combative and unruly to staff. Review of the undated facility policy and procedure titled Resident Rights - Personal Privacy/Confidentiality of Record indicate: It the policy of the facility to provide the resident and or legal representative personal privacy and confidentiality of records in such a manner to acknowledge and respect resident rights.	F 583		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental and individuals with intellectual . §483.20(k)(1) A nursing facility must not admit, on or after , any new residents with: (i) Mental as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental	F 645		

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F 645	Continued From page 3	F 645		

condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services; or
(ii) Intellectual , as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual or authority has determined prior to admission-
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and
(C) Whose attending physician has certified, before admission to the facility that the individual

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F 645	Continued From page 4	F 645		

is likely to require less than 30 days of nursing facility services.

§483.20(k)(3) Definition. For purposes of this section-
(i) An individual is considered to have a mental . . . if the individual has a serious mental defined in 483.102(b)(1).
(ii) An individual is considered to have an intellectual , if the individual has an intellectual . . . , as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to ensure a level 1 Preadmission Screening and Resident Review (PASRR)for individuals with a serious mental illness (SMI), or intellectual , or related conditions (ID)was completed accurately prior to admission and failed to revise the screenings following admission for three (Resident #13, Resident #8 and Resident#12) out of 20 sampled residents. There were 44 residents residing in the facility at the time of the survey.

The findings Included:

Resident #13

During observations on at 08:36 AM, Resident #13 is awake in bed.
On at 07:39 AM Resident #13 was observed in room walking around and stated she is ok, "just getting around for the day."

Observation on at 10:23 A; Resident #13 was her room sitting on the side of the bed, conversing with roommate and stated, "today is a

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F 645	Continued From page 5 good day." Review of the medical records for Resident #13 revealed the resident was admitted to the facility on . Clinical diagnoses included but were not limited to: Unspecified , unspecified severity, without behavioral disturbance, , disturbance, disturbance, , Major , recurrent unspecified. Unspecified is not due to a substance or known physiological condition. Review of the Physician's Orders Sheet for revealed, Resident #13 had orders that included but not limited to: Oral Tablet 25 Milligram (MG) -Give one (1) tablet by one time a day for Unspecified Oral Tablet 5 MG -Give 1 tablet by one time a day for oral tablet 50 MG -give 1 tablet by at bedtime for unspecified , Oral Tablet 7.5 MG -Give 1 tablet by at bedtime for . Record Review of Resident #13's Level I PASRR (Preadmission Screening and Resident Review) documented Section I: PASARR Screen Decision Making: A: Mental Illness ( ) or suspected (check all that apply) - No diagnoses checked off. Findings based on documented history were-Section II Other indicators for PASRR screening Decision-Making: All checked - no. Does individuals have validating documentation to support or related - no. Section III Not a provisional admission. Section . No diagnosis or suspicion of Serious Mental Illness (SMI) or Intellectual	F 645		

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F 645	Continued From page 6 (ID) indicated. Level II PASRR evaluation not required. PASRR Level I completed by a Social Worker at the hospital on . Record review of Resident # 13's Quarterly Minimum Data Set (MDS) dated revealed: Section A 1500 resident is currently considered by the state level II PASRR process to have a SMI or ID or a related condition-Not available. Section C for Patterns documented score ( ) of 11 on a 0-15 scale indicating the resident is moderately . Section I for Active diagnosis documented , , and . Section N indicated that the resident's medications include , , , and . Record review of Resident #13 's Care Plans Reference Date revealed: Resident #13 is on drugs related to Diagnosis of , , , , and is at risk for drug-related adverse effects from medicine. Date Initiated: ...will benefit from the therapeutic effects of medication and be monitored adverse effects daily through the next review date ... consultation and follow-up as needed. Record Review of Resident #13's Consultation dated documented: medications were reviewed and reconciled, the patient was alert and oriented to person and place (x 2). She denied any new or worsening or medical symptoms, including changes in , emergence of ,	F 645		

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F 645	Continued From page 7 features, or further decline ... appeared calm and showed no signs of distress ... denied , or self-injurious behavior. Patient affect was appropriate to the situation, and her behavior was and pleasant throughout the session. There were no or reported. Ongoing monitoring is in place. Resident # 8 Record Review of Resident # 8's admission records revealed Resident #8 was admitted to the facility on and readmitted on . Medical Diagnosis revealed Resident #8's diagnoses included, but not limited to, and Unspecified . Review of Resident #8's Physician Order Sheet dated revealed Resident #8 is currently receiving , Oral Tablet 5 mg (milligrams). Directions: Give 1 tablet by at bedtime related to Unspecified . Review of Resident # 8's PASRR Level I dated /023 revealed no diagnoses checked or identified under 1A. Section 1B for Serious Mental Illness (SMI), Section 2,3 (A/B) and 4 (A/B) were checked. Section II Part A & B were checked. Section was completed. Record Review of a Quarterly Admission Minimum Data Set (MDS) Section A (identification) dated revealed Resident #8 was not considered by the level II PASRR process to have serious mental illness and/or intellectual , or a related condition. Section I revealed Resident #8 had , and	F 645		

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F 645	Continued From page 8	F 645		

Record Review of Care Plan dated revealed Resident # 8 is at risk for possible adverse side effects of , , medications. Goals: Will benefit from the therapeutic effects of medication and be monitored adverse effects daily through next review date. Interventions: Monitor for /behavior and record on behavior sheet. Monitor for drug-related side effects ...Work with MD/Psychiatrist for possible drug reduction.

Resident # 12

Observations on at 8:45 AM, Resident #12 was seated on his bed finishing his breakfast.

Observation on at 10:30 AM Resident # 12 was watching television and did not answer questions asked.

Record review of Resident # 12's clinical records revealed the resident was admitted to the facility on and readmitted on . Clinical diagnoses include Disturbance, , ; Unspecified , not Due to a Substance or Known Physiological Condition and Generalized , .

Review of the Admissions MDS (Minimum Data Set) Section A Identification Information dated revealed the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual , or a related condition documented- NO

Record review of PASRR Level I dated revealed identification of a Serious

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F 645	Continued From page 9	F 645		

Mental Illness under Section 1A and Section 1B was not checked for Serious Mental Illness (SMI). Section 2, Other Indications for PASRR Screen Decision-Making, no questions were answered no indicating the resident had no behaviors. Section 4 PASRR Screen Completion revealed the resident had Serious Mental Illness and the Level II PASRR is required.

Review of Physician Orders and the Medication Administration Records for , revealed Resident # 12 is receiving , Tablet 25 milligrams. 1 tablet by at bedtime for , ; and monitored for , , , Other , .

Record review of Annual Minimum Data Set (MDS) Section C Patterns dated revealed the ( ) summary score was 99 meaning the resident was unable to complete the interview. Review of the Annual MDS Section I Active Diagnosis dated include (other than). Review of the Annual MDS Section N Medications dated revealed the resident was taking , , medication.

The Care Plan initiated on and the next review date documented the resident is on , , drugs and was at risk for drug-related adverse effects from medicine ...Psych consult and follow-up as needed. Work with physician/psychiatrist for possible drug reduction.

Review of Psychiatrist consultation dated revealed the resident with a history of , , , major , (MDD), and

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F 645	Continued From page 10 generalized (GAD) ... receive treatment for his conditions. Assessment: 1. Unspecified not due to a substance or known physiological condition: Oral Tablet 25 mg. 2. Major , recurrent 3. Generalized Interview on at 1:45 PM, the Director of Nursing revealed the Social Services Director (SSD) is responsible for completing the Level I PASRR assessments; and if the SSD does not complete the assessments, then she (DON) is responsible to complete the Level I PASRR. Interview on at 1:30 PM; the Social Services Director revealed she does not have the required license to complete the PASRR assessments. Record review of the Policies and Procedures Subject PASRR Pre-Admission /Screening and Resident Review, Effective date: I- Purpose: Pre-Admission Screening and Resident Review (PASSR) is a federal requirement mandated by the Social Security Act. It is intended to ensure that Medicaid-certified nursing facility applicants and residents with a diagnosis of or suspicion of serious mental illness or , or related conditions are identified and admitted or allowed to remain in the nursing facility only if there is a verified need for such services. -Policy: The facility ensures that all residents admitted to the facility have PASRR Level I done prior to admission to facility or Level II PASRR as indicated by resident's condition and behavior. The facility ensures that PASRR Level I must reflect current condition and diagnosis or	F 645		

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F 645	Continued From page 11 resident. Facility will follow from mandated by AHCA at any given time.	F 645		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the ⌄ and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate,	F 867		

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	105057	A. BUILDING _____ B. WING _____	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINES NURSING HOME	301 NE 141 STREET MIAMI, FL 33161

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F 867	Continued From page 12	F 867		

analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies :
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement

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F 867	Continued From page 13	F 867		

activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and , , of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:

(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;
(iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.
This REQUIREMENT is not met as evidenced by:
Based on observations, interview and record

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F 867	Continued From page 14	F 867		

review, 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 F880- Prevention & Control. As evidenced by: F880 was cited during a Recertification survey ending when the facility failed to implement control procedures. This repeated deficient practice has the potential to affect any of the 44 residents residing in the facility at the time of the survey.

The findings included
Record review of the facility's survey history revealed, during a recertification conducted on , through , , F880- Prevention & Control was cited due to the facility's failure to implement control procedures related to staff's not changing gloves during , care and staff failure to adhere to proper sharps disposal related to used Monitoring supplies.

Review of the facility's policy and procedure titled "Quality Assurance and Performance Improvement" revision dated/02/25 states: These policies are intended to ensure the facility develops a plan that describes the process for conducting QAPI/QAA activities, such as identifying and correcting quality deficiencies as well as opportunities for improvement, which will lead to improvement in the lives of nursing home residents, through continuous attention to quality of care, quality of life, and resident safety.
The facility will develop, implement, and maintain an effective, comprehensive, data driven QAPI program that focuses on indicators of the

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F 867	Continued From page 15 outcomes of care and quality of life. Review of the Quality Assurance and Performance Improvement (QAPI) Committee Meeting Sign-in Sheets dated , , and documented the facility had a QAA Committee had meetings monthly. Interview on at 3:00 PM Administrator (NHA) stated the QAA Committee meets every month, the last meeting was held on . The committee consists of the Medical Director, Administrator, Director of Nursing (DON), Preventionist and all interdisciplinary team members. The purpose of QAPI is to meet with the IDT (interdisciplinary team) staff to make improvements for the residents, measure results, determine what issues to be worked on and need to be corrected. Make improvements and have interventions in place to have better patient/resident outcomes.	F 867		
F 880 SS=D	Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Control The facility must establish and maintain an prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable and . §483.80(a) prevention and control program. The facility must establish an prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 16	F 880		

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling and communicable for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable or before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable or should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of ;
( )When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable or skin from direct contact with residents or their food, if direct contact will transmit the ; and
(vi)The hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 17	F 880		

identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of .

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review and interview, the facility failed to implement control procedures for two Residents (Resident 23 and Resident #34), out of 20 sampled residents. As evidenced by staff failed to dispose used Monitoring supplies in the sharps container, failed to clean the vial before extracting medications via needle syringe and failed to wear Personal protective equipment (PPE) during care for one (Resident # 34)out of one resident reviewed . There were 44 residents residing in the facility at the time of the survey.

The findings Included:

During a Monitoring observation on at 11:08 AM for Resident #34 with Staff A, Licensed Practical Nurse. Staff A prepared the supplies, entered the resident's room, identified the resident, explained treatment, washed , donned gloves, cleaned the residents right index with an , , checked the (BG), the results was 326. Staff A, cleaned the resident's right index again with an , , discarded

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	105057	A. BUILDING _____ B. WING _____	04/30/2025

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F 880	Continued From page 18	F 880		

lancet, test strips and used pads in the garbage can in the resident's room. Staff A exited room, cleaned machine with micro kill-wipes, let dry, returned the unused supplies to the medication cart, checked resident's orders-Eight (8) units of required. Staff A extracted eight (8) units of from the vial using a needle syringe, Staff A did not clean the top of vial with an , before inserting the needle syringe into the vial.

Interview on at 11:32 AM, Staff A revealed she forgot to wipe the top of vial with an , before inserting the syringe needle into the vial to withdraw the 8 units of needed for administration to Resident #34 and was not sure if she was allowed to put any unused supplies taken into a resident's room in the cart and she placed all the used supplies into her gloves and disposed it in the garbage can in the resident's room; and thought that was ok because the used supplies were wrapped in the gloves.

Interview on at 08:36 AM, the Director of Nursing (DON) was informed of the concerns mentioned above related to control procedures and care for the residents.

Review of the facility policy and procedure titled " Control" revision date states: The facility will develop and maintain an effective control program that protects residents, families, visitors and staff by preventing and controlling and communicable as an integral part of the quality assessment performance improvement program. The control program will be in accordance with States

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PINES NURSING HOME	301 NE 141 STREET MIAMI, FL 33161

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F 880	Continued From page 19 and Federal Regulations. and national guidelines. The Preventionist will ensure that appropriate prevention and control measures are taken to provide a safe, sanitary, and comfortable environment to prevent the spread of . On at 10:24 AM during Resident #23's care observation being performed by Licensed Practical Nurse (Staff C) The nurse performed hygiene care gathered supplies and entered Resident #23's room identified the resident explained procedure and provided privacy. Staff C did not put on a gown, Staff C performed hygiene, , care and care, discarded used supplies in a biohazard bag washed exited the resident's room and placed the bag in the biohazard bin (located outside). Review of medical records for Resident #23 revealed, the resident was initially admitted to the facility on and readmitted on . Clinical diagnoses include , and of . Review of the Physician Orders Sheet for revealed, Resident #23 had orders that included but were not limited to: [] Care every shift. For , , revealed, Resident #23 had orders that included but were not limited to: Enhanced Barrier Precautions (EBP) for risk of related to medical device every shift. Review of Resident #23's Quarterly Minimum Data Set (MDS) dated revealed: Resident # 23 is ; needs	F 880		

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F 880	Continued From page 20 substantial or maximal assistance for toileting hygiene and care and has an . Record Review of Resident #23's Care Plan reference date revealed: Resident #23 is at risk for due to use. Interventions included but not limited to: Change , tubing, and drainage bag as ordered, care daily and as needed, and monitor amount, character, color, odor of output, note for recurring . Interview on at 11:08 AM, Staff C revealed, Resident #23's care is done daily and as needed, and handwashing is the number one priority. " control practices we implement for a patient with a [ ] is always following Enhanced Barrier Precautions (EBP) by using Personal Protective Equipment (PPE) and handwashing. PPE includes using gloves, gown, mask, and protection (if needed). PPE helps prevent ." During an interview on at 11:30 AM Staff D, Registered Nurse Supervisor revealed: when a patient is on EBP, there would be PPE inside the patient's room and the nurse should always wear PPE when taking care of patients on EBP. Nurses will know if a patient is on EBP when they receive report at the beginning of shift and the nursing supervisor always tries to reinforce it.	F 880		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	111335	A. BUILDING: _____ B. WING _____	04/30/2025

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N 000	INITIAL COMMENTS A re-licensure survey was conducted at Pines Nursing Home on , , through , , . Deficiencies were identified at the time of the survey	N 000		
N 202	400.022(1)(m), FS Right to Privacy (m) The right to have privacy in treatment and in caring for personal needs; to close room doors and to have facility personnel knock before entering the room, except in the case of an emergency or unless medically contraindicated; and to security in storing and using personal possessions. Privacy of the resident's body shall be maintained during, but not limited to, toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. Residents' personal and medical records shall be confidential and exempt from the provisions of s. 119.07(1). This Statute or Rule is not met as evidenced by: Based on observations record review and interview, the facility failed to safeguard and ensure privacy of residents' confidential Electronic Health Records (EHR); as evidenced by one out of two of the facility's medication carts' computer screen was left unlocked and unattended and a physical note posted on two of two medication carts revealing residents' information. There were 44 residents residing in the facility at the time of the survey. The findings include: On at 08:51 AM during an observation of the facility, a note pertaining to Resident #23's authorized visitors and what steps to follow was	N 202	1. Resident #23 posted information was immediately removed on , and a search of the common facility areas was conducted to ensure that no other resident information was visible to outside sources, no other issues were found. 2. Medication carts and computer were checked for identifiable resident information and no other issues were found. 3. The DON or designee will educate current staff to ensure that personal and/or confidential information is safeguarded. 4. HR will be responsible for training new hires on measures to safeguard information and HIPAA compliance.	

Agency for Health Care Administration

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	111335	A. BUILDING: _____ B. WING _____	04/30/2025

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N 202	Continued From page 1 observed posted on Medication Cart A and Medication Cart B computer screens (Photo evidence). On at 09:15 AM during medication administration observation the Electronic Medication Administration Records (EMAR) on the computer screen for Medication Cart A was left unlocked and unattended with a resident's EMAR information visible (Photo evidence). Interview on at 09:45 AM Registered Nurse (Staff B) stated: "Yes I forgot to lock the computer before going to administer medications to the resident, it was a mistake, I know I am supposed to lock the computer screen when I am not with the medication cart." Interview on at 07:54 AM Director of nursing (DON) revealed the signs were posted on the computers regarding Resident # 23 to make sure all staff, including the as needed (PRN) nursing staff were aware of visitor restrictions for Resident # 23. The signs were supposed to be flipped backwards to the empty side and not displaying residents' information. The brother's behavior is an issue, every time he visits, he refuses to leave the facility. The police had been called several times about the brother, when he takes his brother out on pass, he never brings him to the facility on time and is very combative and unruly to staff. Review of the undated facility policy and procedure titled Resident Rights - Personal Privacy/Confidentiality of Records indicate: It is the policy of the facility to provide the resident and or legal representative personal privacy and confidentiality of records in such a manner to	N 202	5. On , all departments were re-educated by the DON on the importance of residents rights to privacy to ensure that residents names are kept confidential and not posted. 6. The nurse on cart B who left the computer screen open unattended was re-educated by DON on the importance of locking his screen when moving away from the cart. 7. On an in-service was held by the DON with all the nurses on confidentiality and privacy of residents information related to safeguarding personal and confidential information. 8. Nursing supervisor will monitor for compliance daily and Director of Nursing or designee will make random checks weekly to ensure that residents rights to confidentiality and privacy are not being violated for the next 3 months. 9. Findings will be reported monthly in the QA meeting until substantial compliance has been determined, to ensure compliance has been achieved.	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 202	Continued From page 2 acknowledge and respect resident rights. Class III	N 202		

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F 000	INITIAL COMMENTS A recertification survey was conducted at Pines Nursing Home on , through , . The facility was not in compliance with 42 CFR 483, Requirements for Long Term Care Facilities.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(i) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the	F 583		

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

Electronically Signed /2025

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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PINES NURSING HOME	301 NE 141 STREET MIAMI, FL 33161

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F 583	Continued From page 1 Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observations record review and interview, the facility failed to safeguard and ensure privacy of residents' confidential Electronic Health Records (EHR); as evidenced by one out of two of the facility's medication carts' computer screen was left unlocked and unattended and a physical note posted on two of two medication carts revealing residents' information. There were 44 residents residing in the facility at the time of the survey. The findings include: On at 08:51 AM during an observational of the facility, a note pertaining to Resident #23's allowed visitors and what steps to follow (Photo evidence) was observed posted on Medication Cart A and Medication Cart B computer screens. On at 09:15 AM during medication administration observation the Electronic Medication Administration Records (EMAR) screen on the computer on Medication Cart A was left unlocked and unattended with a resident's EMAR information visible (Photo evidence). Interview on at 09:45 AM Registered Nurse (Staff B) stated: "Yes I forgot to lock the computer before going to administer medications to the resident, it was a mistake, I know I am supposed to lock the computer screen when I am not with the medication cart."	F 583	1. Resident #23 posted information was immediately removed on , and a search of the common facility areas was conducted to ensure that no other resident information was visible to outside sources, no other issues were found. 2. Medication carts and computer were checked for identifiable resident information and no other issues were found. 3. The DON or designee will educate current staff to ensure that personal and/or confidential information is safeguarded. 4. HR will be responsible for training new hires on measures to safeguard information and HIPAA compliance. 5. On , , all departments were re-educated by the DON on the importance of residents rights to privacy to ensure that residents names are kept confidential and not posted. 6. The nurse on cart B who left the computer screen open unattended was re-educated by DON on the importance of locking his screen when moving away from the cart. 7. On , an in-service was held by the DON with all the nurses on confidentiality and privacy of residents information related to safeguarding personal and confidential information. 8. Nursing supervisor will monitor for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105057	A. BUILDING _____ B. WING _____	04/30/2025

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F 583	Continued From page 2 Interview on at 07:54 AM Director of nursing (DON) revealed the signs were posted on the computers regarding Resident #23 to make sure all staff, including the as needed (PRN) nursing staff were aware of visitor restrictions for Resident # 23. The signs were supposed to be flipped backwards to the empty side and not displaying residents' information. The brother's behavior is an issue, every time he visits, he refuses to leave the facility. The police had been called several times about the brother, when he takes his brother out on pass, he never brings him to the facility on time and is very combative and unruly to staff. Review of the undated facility policy and procedure titled Resident Rights - Personal Privacy/Confidentiality of Record indicate: It the policy of the facility to provide the resident and or legal representative personal privacy and confidentiality of records in such a manner to acknowledge and respect resident rights.	F 583	compliance daily and Director of Nursing or designee will make random checks weekly to ensure that residents rights to confidentiality and privacy are not being violated for the next 3 months. 9. Findings will be reported monthly in the QA meeting until substantial compliance has been determined, to ensure compliance has been achieved.	
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental and individuals with intellectual . §483.20(k)(1) A nursing facility must not admit, on or after , any new residents with: (i) Mental as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental	F 645		

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F 645	Continued From page 3	F 645		

condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services; or
(ii) Intellectual , as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual or authority has determined prior to admission-
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and
(C) Whose attending physician has certified, before admission to the facility that the individual

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F 645	Continued From page 4 is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental . . . if the individual has a serious mental defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual , if the individual has an intellectual . . . , as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a level 1 Preadmission Screening and Resident Review (PASRR)for individuals with a serious mental illness (SMI), or intellectual , or related conditions (ID)was completed accurately prior to admission and failed to revise the screenings following admission for three (Resident #13, Resident #8 and Resident#12) out of 20 sampled residents. There were 44 residents residing in the facility at the time of the survey. The findings Included: Resident #13 During observations on at 08:36 AM, Resident #13 is awake in bed. On at 07:39 AM Resident #13 was observed in room walking around and stated she is ok, "just getting around for the day." Observation on at 10:23 A; Resident #13 was her room sitting on the side of the bed, conversing with roommate and stated, "today is a	F 645	1. Residents # 8,12,13 PASRR were immediately updated on after finding out that there was some missing information on them. 2. An audit on all current residents to ensure that their PASRR were completed accurately was conducted . 3. Regulations and criteria for completing PASRR were reviewed. 4. Admission personnel was instructed to ensure that PASRR comes in completed with every new admission. 5. Social Service with MDS Coordination will review all PASRR within 72 hours of admission for accuracy to alert D.O.N if there is any discrepancy. 6. If found incorrectly completed the D.O.N will do the PASRR over and social worker will upload updated PASRR into the resident's record. 7. D.O.N or designee will do random checks monthly on all new admission PASRR to ensure compliance for the next 3 months.	

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	105057	A. BUILDING _____ B. WING _____	04/30/2025

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F 645	Continued From page 5 good day." Review of the medical records for Resident #13 revealed the resident was admitted to the facility on . Clinical diagnoses included but were not limited to: Unspecified , unspecified severity, without behavioral disturbance, , disturbance, disturbance, , Major , recurrent unspecified. Unspecified is not due to a substance or known physiological condition. Review of the Physician's Orders Sheet for revealed, Resident #13 had orders that included but not limited to: Oral Tablet 25 Milligram (MG) -Give one (1) tablet by one time a day for Unspecified Oral Tablet 5 MG -Give 1 tablet by one time a day for oral tablet 50 MG -give 1 tablet by at bedtime for unspecified , Oral Tablet 7.5 MG -Give 1 tablet by at bedtime for Record Review of Resident #13's Level I PASRR (Preadmission Screening and Resident Review) documented Section I: PASARR Screen Decision Making: A: Mental Illness ( ) or suspected (check all that apply) - No diagnoses checked off. Findings based on documented history were-Section II Other indicators for PASRR screening Decision-Making: All checked - no. Does individuals have validating documentation to support or related - no. Section III Not a provisional admission. Section . No diagnosis or suspicion of Serious Mental Illness (SMI) or Intellectual	F 645	8. Findings will be brought to the monthly QA meetings until such time as substantial compliance has been determined, to ensure compliance has been achieved	

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F 645	Continued From page 6 (ID) indicated. Level II PASRR evaluation not required. PASRR Level I completed by a Social Worker at the hospital on . Record review of Resident # 13's Quarterly Minimum Data Set (MDS) dated revealed: Section A 1500 resident is currently considered by the state level II PASRR process to have a SMI or ID or a related condition-Not available. Section C for Patterns documented score ( ) of 11 on a 0-15 scale indicating the resident is moderately . Section I for Active diagnosis documented , , and . Section N indicated that the resident's medications include , , , , and . Record review of Resident #13 's Care Plans Reference Date revealed: Resident #13 is on drugs related to Diagnosis of , , , , and is at risk for drug-related adverse effects from medicine. Date Initiated: ...will benefit from the therapeutic effects of medication and be monitored adverse effects daily through the next review date ... consultation and follow-up as needed. Record Review of Resident #13's Consultation dated documented: medications were reviewed and reconciled, the patient was alert and oriented to person and place (x 2). She denied any new or worsening or medical symptoms, including changes in , emergence of ,	F 645		

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F 645	Continued From page 7 features, or further decline ... appeared calm and showed no signs of distress ... denied , or self-injurious behavior. Patient affect was appropriate to the situation, and her behavior was and pleasant throughout the session. There were no or reported. Ongoing monitoring is in place. Resident # 8 Record Review of Resident # 8's admission records revealed Resident #8 was admitted to the facility on and readmitted on . Medical Diagnosis revealed Resident #8's diagnoses included, but not limited to, and Unspecified . Review of Resident #8's Physician Order Sheet dated revealed Resident #8 is currently receiving , Oral Tablet 5 mg (milligrams). Directions: Give 1 tablet by at bedtime related to Unspecified . Review of Resident # 8's PASRR Level I dated /023 revealed no diagnoses checked or identified under 1A. Section 1B for Serious Mental Illness (SMI), Section 2,3 (A/B) and 4 (A/B) were checked. Section II Part A & B were checked. Section was completed. Record Review of a Quarterly Admission Minimum Data Set (MDS) Section A (identification) dated revealed Resident #8 was not considered by the level II PASRR process to have serious mental illness and/or intellectual , or a related condition. Section I revealed Resident #8 had , and	F 645		

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	105057	A. BUILDING _____ B. WING _____	04/30/2025

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F 645	Continued From page 8	F 645		

Record Review of Care Plan dated revealed Resident # 8 is at risk for possible adverse side effects of , , medications. Goals: Will benefit from the therapeutic effects of medication and be monitored adverse effects daily through next review date. Interventions: Monitor for /behavior and record on behavior sheet. Monitor for drug-related side effects ...Work with MD/Psychiatrist for possible drug reduction.

Resident # 12

Observations on at 8:45 AM, Resident #12 was seated on his bed finishing his breakfast.

Observation on at 10:30 AM Resident # 12 was watching television and did not answer questions asked.

Record review of Resident # 12's clinical records revealed the resident was admitted to the facility on and readmitted on . Clinical diagnoses include Disturbance, , ; Unspecified , not Due to a Substance or Known Physiological Condition and Generalized , .

Review of the Admissions MDS (Minimum Data Set) Section A Identification Information dated revealed the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual , or a related condition documented- NO

Record review of PASRR Level I dated revealed identification of a Serious

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	105057	A. BUILDING _____ B. WING _____	04/30/2025

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PINES NURSING HOME	301 NE 141 STREET MIAMI, FL 33161

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F 645	Continued From page 9	F 645		

Mental Illness under Section 1A and Section 1B was not checked for Serious Mental Illness (SMI). Section 2, Other Indications for PASRR Screen Decision-Making, no questions were answered no indicating the resident had no behaviors. Section 4 PASRR Screen Completion revealed the resident had Serious Mental Illness and the Level II PASRR is required.

Review of Physician Orders and the Medication Administration Records for , revealed Resident # 12 is receiving , Tablet 25 milligrams. 1 tablet by at bedtime for , ; and monitored for , , , Other , .

Record review of Annual Minimum Data Set (MDS) Section C Patterns dated revealed the ( ) summary score was 99 meaning the resident was unable to complete the interview. Review of the Annual MDS Section I Active Diagnosis dated include (other than). Review of the Annual MDS Section N Medications dated revealed the resident was taking , , medication.

The Care Plan initiated on and the next review date documented the resident is on , , drugs and was at risk for drug-related adverse effects from medicine ...Psych consult and follow-up as needed. Work with physician/psychiatrist for possible drug reduction.

Review of Psychiatrist consultation dated revealed the resident with a history of , , , major , (MDD), and

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	105057	A. BUILDING _____ B. WING _____	04/30/2025

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PINES NURSING HOME	301 NE 141 STREET MIAMI, FL 33161

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F 645	Continued From page 10 generalized (GAD) ... receive treatment for his conditions. Assessment: 1. Unspecified not due to a substance or known physiological condition: Oral Tablet 25 mg. 2. Major , recurrent 3. Generalized Interview on at 1:45 PM, the Director of Nursing revealed the Social Services Director (SSD) is responsible for completing the Level I PASRR assessments; and if the SSD does not complete the assessments, then she (DON) is responsible to complete the Level I PASRR. Interview on at 1:30 PM; the Social Services Director revealed she does not have the required license to complete the PASRR assessments. Record review of the Policies and Procedures Subject PASRR Pre-Admission /Screening and Resident Review, Effective date: I- Purpose: Pre-Admission Screening and Resident Review (PASSR) is a federal requirement mandated by the Social Security Act. It is intended to ensure that Medicaid-certified nursing facility applicants and residents with a diagnosis of or suspicion of serious mental illness or , or related conditions are identified and admitted or allowed to remain in the nursing facility only if there is a verified need for such services. -Policy: The facility ensures that all residents admitted to the facility have PASRR Level I done prior to admission to facility or Level II PASRR as indicated by resident's condition and behavior. The facility ensures that PASRR Level I must reflect current condition and diagnosis or	F 645		

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PINES NURSING HOME	301 NE 141 STREET MIAMI, FL 33161

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F 645	Continued From page 11 resident. Facility will follow from mandated by AHCA at any given time.	F 645		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the ⌄ and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate,	F 867		

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PINES NURSING HOME	301 NE 141 STREET MIAMI, FL 33161

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F 867	Continued From page 12	F 867		

analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies :
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105057	A. BUILDING _____ B. WING _____	04/30/2025

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F 867	Continued From page 13 activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and , , of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, interview and record	F 867	1. On , , , the QAPI committee	

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	105057	A. BUILDING _____ B. WING _____	04/30/2025

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PINES NURSING HOME	301 NE 141 STREET MIAMI, FL 33161

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F 867	Continued From page 14	F 867		

review, 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 F880- Prevention & Control. As evidenced by: F880 was cited during a Recertification survey ending when the facility failed to implement control procedures. This repeated deficient practice has the potential to affect any of the 44 residents residing in the facility at the time of the survey.

The findings included
Record review of the facility's survey history revealed, during a recertification conducted on , through , , F880- Prevention & Control was cited due to the facility's failure to implement control procedures related to staff's not changing gloves during care and staff failure to adhere to proper sharps disposal related to used Monitoring supplies.

Review of the facility's policy and procedure titled "Quality Assurance and Performance Improvement" revision dated/02/25 states: These policies are intended to ensure the facility develops a plan that describes the process for conducting QAPI/QAA activities, such as identifying and correcting quality deficiencies as well as opportunities for improvement, which will lead to improvement in the lives of nursing home residents, through continuous attention to quality of care, quality of life, and resident safety.
The facility will develop, implement, and maintain an effective, comprehensive, data driven QAPI program that focuses on indicators of the

met to discuss and re-invent the facility current QAPI plan that failed to prevent repeated deficiency related to control practice as staff failed to adhere to proper sharps disposal of used monitoring supplies. Upon discussion it was determined that failure in the system occurred and intervention to address the would be implemented. During monthly meetings control and personal privacy audit will be collected for tracking and monitoring.
Any adverse finding discovered through monitoring will be attended amongst the interdisciplinary team during QAPI gatherings. Department heads will ensure all new processes are implemented in applicable locations.
2. New hire files will be reviewed during the QAPI meeting to ensure educational training on control and residents rights to privacy/confidentiality is received.
3. The facility QAPI process and current performance improvement plans were reviewed and revision needed made by the Administrator to ensure that no other areas were affected. DON implemented training, education, and plan of correction expressed in other to address failures in system discussed during meeting on .
4. A performance improvement project was implemented on control practices to include previous survey

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	105057	A. BUILDING _____ B. WING _____	04/30/2025

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F 867	Continued From page 15 outcomes of care and quality of life. Review of the Quality Assurance and Performance Improvement (QAPI) Committee Meeting Sign-in Sheets dated , , and documented the facility had a QAA Committee had meetings monthly. Interview on at 3:00 PM Administrator (NHA) stated the QAA Committee meets every month, the last meeting was held on . The committee consists of the Medical Director, Administrator, Director of Nursing (DON), Preventionist and all interdisciplinary team members. The purpose of QAPI is to meet with the IDT (interdisciplinary team) staff to make improvements for the residents, measure results, determine what issues to be worked on and need to be corrected. Make improvements and have interventions in place to have better patient/resident outcomes.	F 867	citations related to control (e.g. monitoring supplies disposal, cleaning vial, PPE usage when performing care) 5. On , the preventionist and the Director of Nursing were in-serviced by the administrator on the revised QAPI/QA&A policy and procedures. After conducting training the Administrator observed compliance by each staff member. 6. The administrator re-educated and reminded all department heads of the importance of following the QAPI Policy & Procedures on . After conducting training the Administrator observed compliance by each staff member. 7. The administrator will conduct QAPI audits once a month for the next 3 months. Administrator will track and monitor audits performed to verify systems are working. 8. These audits will be presented to the QA&A committee monthly for recommendations. 9. The committee will determine the need for further auditing beyond the three months if any.	
F 880 SS=D	Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Control The facility must establish and maintain an prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the	F 880		

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F 880	Continued From page 16 development and transmission of communicable and . §483.80(a) prevention and control program. The facility must establish an prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling and communicable for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable or before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable or should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of ; ( )When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.	F 880		

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F 880	Continued From page 17 (v) The circumstances under which the facility must prohibit employees with a communicable or skin from direct contact with residents or their food, if direct contact will transmit the ; and (vi)The hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of . §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to implement control procedures for two Residents (Resident 23 and Resident #34), out of 20 sampled residents. As evidenced by staff failed to dispose used Monitoring supplies in the sharps container, failed to clean the vial before extracting medications via needle syringe and failed to wear Personal protective equipment (PPE) during care for one (Resident # 34)out of one resident reviewed . There were 44 residents residing in the facility at the time of the survey. The findings Included: During a Monitoring observation	F 880	1. The involved nurses were in-serviced on , by the Director of Nursing, on the importance of preventing the spread of via instruction of proper place to dispose of used Accu-Chek supplies, wiping vial. before drawing the desired units, and wearing PPE while providing care. 2. The DON implemented a performance improvement project with the nurse causing repeat citation for one month on control. 3. On , 9 2025 an in-service was done by the DON with all nurses to ensure	

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F 880	Continued From page 18 on at 11:08 AM for Resident #34 with Staff A, Licensed Practical Nurse. Staff A prepared the supplies, entered the resident's room, identified the resident, explained treatment, washed , donned gloves, cleaned the residents right index with an , , checked the (BG), the results was 326. Staff A, cleaned the resident's right index again with an , , discarded lancet, test strips and used pads in the garbage can in the resident's room. Staff A exited room, cleaned machine with micro kill-wipes, let dry, returned the unused supplies to the medication cart, checked resident's orders-Eight (8) units of required. Staff A extracted eight (8) units of from the vial using a needle syringe, Staff A did not clean the top of vial with an , before inserting the needle syringe into the vial. Interview on at 11:32 AM, Staff A revealed she forgot to wipe the top of vial with an , before inserting the syringe needle into the vial to withdraw the 8 units of needed for administration to Resident #34 and was not sure if she was allowed to put any unused supplies taken into a resident's room in the cart and she placed all the used supplies into her gloves and disposed it in the garbage can in the resident's room; and thought that was ok because the used supplies were wrapped in the gloves. Interview on at 08:36 AM, the Director of Nursing (DON) was informed of the concerns mentioned above related to control procedures and care for the residents.	F 880	that everyone is reminded of the proper disposal of used Accu-Chek supplies as well as their role in preventing and controlling in the building. The DON demonstrated techniques through exercises of the proper way to prevent the spread of . One on one return demonstration was conducted. DON and nursing supervisor observed compliance by each nurse. 4. D.O.N or designee will do some extra shadowing of the nurses involved to monitor the quality of their control practices. 5. Nursing supervisor will do random checks weekly to monitor for compliance for the next 3 months. 6. Findings will be discussed monthly in QA meetings until substantial compliance has been achieved.	

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F 880	Continued From page 19 Review of the facility policy and procedure titled " Control" revision date states: The facility will develop and maintain an effective control program that protects residents, families, visitors and staff by preventing and controlling and communicable as an integral part of the quality assessment performance improvement program. The control program will be in accordance with States and Federal Regulations. and national guidelines. The Preventionist will ensure that appropriate prevention and control measures are taken to provide a safe, sanitary, and comfortable environment to prevent the spread of . On at 10:24 AM during Resident #23's care observation being performed by Licensed Practical Nurse (Staff C) The nurse performed hygiene care gathered supplies and entered Resident #23's room identified the resident explained procedure and provided privacy. Staff C did not put on a gown, Staff C performed hygiene, care and care, discarded used supplies in a biohazard bag washed exited the resident's room and placed the bag in the biohazard bin (located outside). Review of medical records for Resident #23 revealed, the resident was initially admitted to the facility on and readmitted on . Clinical diagnoses include and of . Review of the Physician Orders Sheet for revealed, Resident #23 had orders that included but were not limited to: []	F 880		

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F 880	Continued From page 20 Care every shift. For , , revealed, Resident #23 had orders that included but were not limited to: Enhanced Barrier Precautions (EBP) for risk of related to medical device every shift. Review of Resident #23's Quarterly Minimum Data Set (MDS) dated revealed: Resident # 23 is ; needs substantial or maximal assistance for toileting hygiene and care and has an . Record Review of Resident #23's Care Plan reference date revealed: Resident #23 is at risk for due to use. Interventions included but not limited to: Change , tubing, and drainage bag as ordered, care daily and as needed, and monitor amount, character, color, odor of output, note for recurring . Interview on at 11:08 AM, Staff C revealed, Resident #23's care is done daily and as needed, and handwashing is the number one priority. " control practices we implement for a patient with a [ ] is always following Enhanced Barrier Precautions (EBP) by using Personal Protective Equipment (PPE) and handwashing. PPE includes using gloves, gown, mask, and protection (if needed). PPE helps prevent ." During an interview on at 11:30 AM Staff D, Registered Nurse Supervisor revealed: when a patient is on EBP, there would be PPE inside the patient's room and the nurse should always wear PPE when taking care of patients on	F 880		

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F 880	Continued From page 21 EBP. Nurses will know if a patient is on EBP when they receive report at the beginning of shift and the nursing supervisor always tries to reinforce it.	F 880		