STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS  (X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER: 1163096				(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVE 07/28/2025	URVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER FOUNTAIN MANOR HEALTH & REHABILITATION CENTER				REET ADDRESS, CITY, STATE, ZIP COE NE 135TH ST , NORTH MIAMI, Florida			
X4) ID REFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG			(X5) COMPLETION DATE	
0000	2025010894, was conducted	aint numbers 2025010806 and at Fountain Manor Health &	N0000			08/15/2025	
0204 S ≈ D	A complaint survey for complaint numbers 2025010806 and 2025010894, was conducted at Fountain Manor Health & Rehabilitation Center on July 28, 2025. Deficiencies were identified at the time of survey.  Right to be Free from Abuse, Restraints, etc  CFR(s): 400.022(1)(o), FS  400.022, F. S. (1)(o)  All licensees of nursing home facilities shall adopt and make public a statement of the rights and responsibilities of the residents of such facilities and shall treat such residents in accordance with the provisions of that statement. The statement shall assure each resident the following:  (o) The right to be free from mental and physical abuse, sexual abuse, neglect, exploitation, corporal punishment, extended involuntary seclusion, and physical abuse, curporal punishment, extended involuntary seclusion, and physical abuse, corporal punishment, extended involuntary seclusion, and physical abuse, corporal punishment, extended involuntary seclusion, and physical abuse, corporal punishment, extended involuntary seclusion, and physical abuse is considered to the second punishment of the security of the second punishment and physical abuse is considered to the second punishment and punishment and punishment and punishment and physical abuse, corporal punishment, extended involuntary seclusion, and physical and chemical restraints, accept those residents admitted by the second punishment of the second punishment of the second punishment of the second punishment of the case of use of a chemical restraint, a physician shall be consulted immediately thereafter, Restraints may not be used in lieu of staff supervision or merely for staff convenience, for punishment, or for reasons other than resident protection or safety.  This LICENSURE REQUIREMENT is NOT MET as evidenced by fleeters after Restraints and protect the residents right to be free from physical abuse for one (Resident #1) out of three sampled residents as evidenced by a federal		: :	Plan of Correction-Complaint Investigations for #2025010806 and 20250108094, was conducted on July 28, 2025-Ju 2025  Citation: F600 (D/ N204-Class: III, Isolated) Corrective action(s) will be accomplished for thor residents found to have been affected by the defi practice.  On 07/22/2025, after reporting the incident, Resist if had a head to toe assessment and pain asses completed: Medical Doctor and Psychiatrist were notified; MP ordered X-rays and no fractures were identified. The facility reported the abuser reporter Adult Protective Services (DCF), police and repowern to AHCA on 07/22/2025, that R (Mernal Heal Technicaln) was terminated from employment.  On 7/23/2025, the Risk Manager of the facility conducted in-service education for all staff membals abuse; abuse prevention (familiary difficult resident/residents with desirent act or there of aller mental health diagnosis), and reporting of abuse is deferred action of other resident be affected by the same deficient practice and we corrective action with lie staken AI residents have potential to be affected by this deficient practice.  On 7/24/2025, ADON Interviewed other resident to nesure that they had not been subject to abuse		t ent	

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

(X6) DATE

Florida Stat	e Department of Health					
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER: 1163096		Ą	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURV	RVEY COMPLETED	
	NAME OF PROVIDER OR SUPPLIER FOUNTAIN MANOR HEALTH & REHABILITATION CENTER			TREET ADDRESS, CITY, STATE, ZIP COI 10 NE 135TH ST , NORTH MIAMI, Florida		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	NT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COI X (EACH CORRECTIVE ACTION CROSS-REFERENCED APPROPRIATE DEFIC	SHOULD BE TO THE	(X5) COMPLETIC DATE
N0204 SSS = D	Continued from page 1 report submitted by the facilia allegation of physical abuse- towards Resident #1. There in the facility at the time of six The findings Included: On 7/22/25 the facility submit alleging Resident #1 was phealth technician, Staff A. On 7/28/25, The facility verifierminated Staff A's employr On 07/28/20/25 Resident #1 patio in stable condition. On 7/28/25 at 9:55 AM Resid (translated by other surveyor allegation and stated, 1 am revoept one person. That staff floor, and he dragged me to Record review of Resident #1 revealed the resident was act diagnosis that include: Demetincephalopastry. Depression Repeated falls, Difficulty in wo Osteoarthrist.  Record review of a Quarterly with a reference date of 7/8/s is moderately impaired cogn concerns, was independent it living and required chair/hed Record review of a Care plan reviewed/revised on 7/24/25 exhibited behaviors: spitting to hit a staff member with he that included: Maintain safe of aggression.  Record review of Resident #1 for March 2025 revealed and milligrams (mg) tablet by mo Dementia, Escalalopram oxid once a day for Depression, Cmouth at bedtime for Psycholagilation every shift.  Record review of a Progress revealed Resident #1 sustain revenued Resident #1 sustain revealed Resident #1 susta	from a staff member were 130 residents residing invey.  Itted a federal report [] siscally abused by Mental ed the allegation and nent.  was observed seated on the date of the siscally abused by Mental ed the allegation and nent.  It was interviewed on the staff of the siscally about the pleased with the staff of the member of the siscally about the pleased with the staff of the member of the siscally sis	N0204	Conlinued from page 1 additional complaints were identified. On 7/23/2025, the Risk Manager facilities in-service education for all staff membabuse prevention (handlining difficult resident/residents with dementia or oth mental health diagnosis); and reporting Measures will be put into place or what changes you will make to ensure that the practice does not recur On 7/23/2025, the Risk Manager of the conducted in-service education for all status; abuse prevention (handlining differed in the conducted in-service education for all status; abuse prevention finandlining differed in the resident with dementia or oth mental health diagnosis); and reporting The ADON, or designee, will conduct with current residents to identify and actions will be taken, as necessary.  The Abuse Coordinator, or designee, vi interviews with staff members on abus prevention and reporting requirements interviews will be completed weekly x-broblems identified will be investigation and an actions will be taken, as necessary.  The Abuse Coordinator, or designee, vi interviews will be investigation and preventing requirements interviews will be completed weekly x-broblems identified will be investigation appropriate actions will be implemented. All interviews will be esubmitted to the Adesignee, weekly for evaluation of tren educational needs.  Corrective action(s) will be monitored the deficient practice will not recur.  The findings from the interview, after weeks, will be determined by the QAPI Committees.  Corrective action taken as a result of the will be submitted Administrator, or designed and QAPI Committees monthly for 6 in quarterly for 4 quarters.	ars on abuse; ere challenging of abuse.  It systematic he deficient  It systematic he	

		0/4) DDO (IDED/OLIDE:		WOLLD TO E OCUCENT	000 0175	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER: 1163098		LIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	07/28/2025	RVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER FOUNTAIN MANOR HEALTH & REHABILITATION CENTER			- 1	TREET ADDRESS, CITY, STATE, ZIP C 10 NE 135TH ST , NORTH MIAMI, Flori		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF C X (EACH CORRECTIVE ACTH CROSS-REFERENCE APPROPRIATE DEF	ON SHOULD BE D TO THE	(X5) COMPLETION DATE
NO204 SSS ≈ D	Continued from page 2 area, reported pain in the left a physical assessment was left knee a bruise of about it no the right arm a bruise of re reported pain when bending walk, on a scale of 1 to 194 was 4, and she was offered ; refused. Vitals signs were wit the patient signs were wit the patient denied vomitling, other positive findings were re exam. Nurse Practitioner was order to perform right wiss, ic received and carried out. The Record review of the facility Identifying Types of Abuse Pt the abuse prevention strateg and contractors hired by the be able to Identify the differe may occur against residents During an interview on 7728/t Manager, Registered Nurse approximately 4:00 PM while told me that Resident #11 was from a chair onto the floor an that time [Staff A, Mental He (Resident #1) out of the chair an ash tray and threvi it at [S Technician]. Then [Staff A, Mind the destile, Immedia Administrator, and the came then I completed a full assess the paid on the came then I completed a full assess the paid on the formation of the came then I completed a full assess the paid on the formation of the came then I completed a full assess the paid on the formation of the came then I completed a full assess the paid on the formation of the came then I completed a full assess the paid on the full of the came then I completed a full assess the paid on the full of the came then I completed a full assess the paid on the full of the came then I completed a full assess the paid on the full of the came then I completed to the that technician] was aggressive it The administrator tooked at that the floor and and in the full of the came the federal report. I notified it Department of Children and came and DeCF came and in Administrator for Children and came and DeCF came and in	serformed and found on her rece centimeters (cm), and toout one on, the resident the knee but she was able to her reported that the pain bain medication but she him normal limits, and or shortness of breath. No toted on the physical scalled and new stal x rays rm, and left knee for a stall was shortness of the stall resident should be	N0204			

	te Department of Health		-		1	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS  (X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER: 1163096		A	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SUR 07/28/2025	VEY COMPLETE	
NAME OF PROVIDER OR SUPPLIER FOUNTAIN MANOR HEALTH & REHABILITATION CENTER			1	TREET ADDRESS, CITY, STATE, ZIP C 90 NE 135TH ST , NORTH MIAMI, Flori		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	NT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFI TAG		DN SHOULD BE D TO THE	(X5) COMPLETIO DATE
N0204 \$S\$ ≠ D	the resident's arm and snatic chair where the resident was threw an ash tray towards [S technician] and started trying, health technician]. [Staff A, h blocked the hits with the bag onto the floor in a sitting position of the floor in a sitting position of the floor ground and escrows. [Staff A, Mental health report the incident. There we area. [Staff A, Mental health rough and there was no new area.	DCF investigator stated . I spoke with [Statif A, and discovered [Resident #1] ive days and was get digareties and alth Technician]. I viewed was get digareties and alth Technician]. I viewed wowd [Statif A, Mental the patio and [Resident toor and [Statif A, Mental the backpact then grabbed he resident felt."  PM, with the Director of gedions; he stated: "The on 71/22/25 around 4:00 PM or 10 PM o	N0204			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS  (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER: 1163096		LIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SUR 07/28/2025	VEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER FOUNTAIN MANOR HEALTH & REHABILITATION CENTER			- 1	REET ADDRESS, CITY, STATE, ZIP CO O NE 135TH ST , NORTH MIAMI, Florid		
(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 CC (EACH CORRECTIVE ACTIO CROSS-REFERENCEI APPROPRIATE DEFIG	N SHOULD BE TO THE	(X5) COMPLETION DATE
N0204 SS = D	Continued from page 4 Mental health technician], [Sit technician] used the bookba touched [Resident#1] in the 1 on the Boor, then got up and [Staff A, Mental health technical the resident health technical then grable arm and inside. I investigate reviewing the footage and inf family, and staff. We concludive erifled, and the employee w On 7/29/25 at 9-22 am The S Abuse Coordinator revealed concluded and the allegation verified.  Class III	ji n defense and the bookbag ace and the resident fell threw an ash tray at ician]. [Staff A. Mental ed [Resident #1] by the this incident by erriewing other residents, ad that the allegation was as terminated on 7/28/25.* icicial services Director/ the investigation was	N0204			

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS  (X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER: 105172		IA.			(X3) DATE SURVEY COMPLETED 07/28/2025		
	F PROVIDER OR SUPPLIER IN MANOR HEALTH & REHAL	BILITATION CENTER			REET ADDRESS, CITY, STATE, ZIP COD NE 135TH ST , NORTH MIAMI, Florida,		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID REFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED APPROPRIATE DEFICI	SHOULD BE TO THE	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS  A complaint survey for complaint numbers 2025010806 and 2025010894, was conducted on July 28, 2025, at Fountialn Manor Health & Rehabilitation Center. The Solitily was not in compliance with Code of Federal Regulations (CFR) 42, PART 483, Requirement for Long-Term Care Facilities.			0000			08/15/2025
F0600 SS = D	Free from Abuse and Neglec CFR(s): 483.12 (e)(1) §483.12 Freedom from Abus The resident has the right to negled, misappropriation of exploitation as defined in this but is not limited to freedom ti involuntary socusion and am restraint not required to treat symptoms.	a, Neglect, and Exploitation be free from abuse, resident property, and subpart. This includes rom corporal punishment, physical or chemical	F	9600	Plan of Correction-Complaint Investigat #2025010894, was conducted on July 28 2025 Citation: F600 (D/ N204-Class: III, Isolat Corrective action(s) will be accomplish residents found to have been affected b practice.	i, 2025-July 29, ted)	08/15/2025
	physical abuse, corporal pun seclusion; This REQUIREMENT is NOT Based on observations, inter facility failed to protect the re free from physical abuse for three sampled residents as a report submitted by the facility allegation of physical abuse of towards Resident #1. There vi in the facility at the time of su The findings Included:  On 7/22/25 the facility submit	\$483.12(a) The facility must- \$483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This RECUIREMENT is NOT MET as evidenced by: Based on observations, interviews and record review the facility failed to protect the residents right to be free from physical abuse for one (Resident #1) out of three sampled residents as evidenced by a federal report submitted by the facility regarding a verified allegation of physical abuse from a staff member towards Resident #1. There were 130 residents residing in the facility at the time of survey.			On 07722/2025, after reporting the incid #1 had a head to be assessment and pt completed. Medical Doctor and Psychia notified, NP ordered X-rays and no fact dentified. The facility reported the abus Adult Protoctive Services (DCP), police went to AHCA on 07722/2025, in according to the protoctive Services (DCP), police went to AHCA on 07722/2025, in according to the conducted in-service education for all at Subuse; abuse prevention (flandlining differsident/residents with dementia or other mental health diagnossis), and reporting identification of other residents having it be affected by the same deficient practice of the protocome of the proto	iain assessment first were urnes were er exported to and reported dance with the intal Health yment. facility laff members on ficult enging of abuse bottential to ce and what ints have the practice.	

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

Facility ID: 111302

(X6) DATE

	ENT OF HEALTH AND HUMAN FOR MEDICARE & MEDICAID				F	ORM APPROVED 1B NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER: 105172		A	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/28/2025		
1	OF PROVIDER OR SUPPLIER AIN MANOR HEALTH & REHA	BILITATION CENTER	- 1	TREET ADDRESS, CITY, STATE, ZIP COE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	NT OF DEFICIENCIES IT BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFU TAG		SHOULD BE TO THE	(X5) COMPLETION DATE
F0600 SS = D	for March 2025 revealed ord milligrams (mg) tablet by mo Dementia, Escitalopram oxa once a day for Depression, C mouh at bedtime for Psychologitation every shift.  Record review of a Progress revealed Resident #1 sustail area, reported pain in the let a physical assessment was , left knee a bruise of about #1. left knee a bruise of about #1.	was observed seated on the  dent#1 was interviewed on the team) about the  oleased with the staff if it it, I fell to the my room.  1's demographic sheet initiated on 03/31/2025 with initiate psychosis, Syncope and collapse, alking, and / Minimum Data Set (MDS) 25 indicated Resident #1 itively, had no behavior for activities of daily -to-chair transfers.  initiated on 5/21/25 and revealed Resident #1 at staff and attempting r shoe with interventions distance during episodes  1's Physicians Orders Sheet ers included Memantine 5 ult twice a day for the total product of the staff and the best of the staff and the staff and attempting shoe with interventions distance during episodes  1's Physicians Orders Sheet ers included Memantine 5 ult twice a day for sheet a fast of the staff as 10 mg tablet by alsa nd to monitor for  Note written on 7/22/25 hed a fall in the patic t knee and right forearm, performed and found on her rec centimeters(cm), and	F0600	additional complaints were identified.  On 7/23/2025, the Risk Manager facility in-service education for all staff membe abuse prevention (fandlining difficult resident/residents with dementia or oth mental health diagnosis); and reporting Measures will be put into place or what changes you will make to ensure that it practice does not recur.  On 7/23/2025, the Risk Manager of the conducted in-service education for all is abuse; abuse prevention (handlining difficult resident/residents with dementia or oth mental health diagnosis); and reporting resident/residents with dementia or oth mental health diagnosis); and reporting actions will be taken, as necessary.  The ADON, or designee, will conduct rawth current residents to identify any abuse/reglect/mistreatment. No less the will be completed weekly x 4 weeks. Ar identified will be investigation and an actions will be taken, as necessary.  The Abuse Coordinator, or designee, w interviews with staff members on abuse prevention and reporting requirements, interviews will be completed weekly x 4 problems detentified will be investigation appropriate actions will be sumptited to the A designee, weekly for evaluation of trend educational needs.  Corrective action(s) will be monitored to deficient practice will not recur.  The findings from the interview, along videntified freeds, educational needs, are corrective action taken as a result of the will be summitted. Administrator, or designeed, and corrective action taken as a result of the will be summitted.	rs on abuse; er challenging of abuse. systematic the deficient facility taff members on ficult taff members on ficult er challenging of abuse. and for interviews an 10 interviews an 10 interviews ty problems spropriete sill conduct random to abuse. Sill conduct random to abuse to and any to abuse to abuse to abuse the with any to any to abuse the with any to any	
	reveated Resident #1 sustain area, reported pain in the left a physical assessment was left knee a bruise of about the on the right arm a bruise of	ned a fall in the patio  It knee and right forearm, performed and found on her wee centimeters(cm), and about one cm, the resident the knee but she was able to		identified trends, educational needs, an corrective action taken as a result of the	id any e findings gnee, to the QA	

was 4, and she was offered pain medication but she refused. Vitals signs were within normal limits, and the patient denied vomiting, or shortness of breath. No other positive findings were noted on the physical

Correction Date: 08/15/2025

	ENT OF HEALTH AND HUMAN FOR MEDICARE & MEDICAID						FORM APPROVEI OMB NO. 0938-039
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDER/SUPPLIER/CLI/DENTIFICATION NUMBER: 105172		LIA		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETER 07/28/2025	
	NAME OF PROVIDER OR SUPPLIER FOUNTAIN MANOR HEALTH & REHABILITATION CENTER				REET ADDRESS, CITY, STATE, ZIP COL D NE 135TH ST , NORTH MIAMI, Florida		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	NT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION)	PR	ID REFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED APPROPRIATE DEFIC	I SHOULD BE TO THE	(X5) COMPLETION DATE
F0600 SS = D	Continued from page 2 exam. Nurse Practitioner vas order to perform right wire, a received and carried out. The Record review of the facility's identifying the second review of the facility's identifying the second review of the second revi	rum, and left knees e family was notified.  3 Policy tilled e family was notified.  3 Policy tilled colory and the family was notified.  5 Policy tilled colory and the family was notified.  5 Policy tilled the family and the family of the f	FO	600			

video surveillance, and it showed [Staff A, Mental

	FOR MEDICARE & MEDICAID						IB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDER/SUPPLIER/SU			LIA		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVE 07/28/2025	EY COMPLETED
	NAME OF PROVIDER OR SUPPLIER FOUNTAIN MANOR HEALTH & REHABILITATION CENTER				REET ADDRESS, CITY, STATE, ZIP COL NE 135TH ST , NORTH MIAMI, Florida		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	NT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION)	PR	D EFIX AG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED APPROPRIATE DEFIC	SHOULD BE TO THE	(X5) COMPLETION DATE
F0600 SS = D	the resident's arm and snato- chair where the resident was threw an ash tray towards [S technician] and started tryin health technician]. [Staff A. In blocked the hits with the bag onto the floor in a sitting pos [Staff A. Mental health techn #1] from the ground and eso room. [Staff A, Mental health report the incident. There we area. [Staff A, Mental health rough and there was no nee unacceptables. A head-toe and Psy x-rays showed on facture." The surveyor requested to vi incident, but the DON reveal been recorded over. Interview on 7288/25 at 3.36 stated: "An incident of physic me by The Unit Manager. In Coordinator, At that time, I, vi and I saw [Resident#1] throw technician bookbeg] and sit. Mental health technician] gre by the arm and out the chair, seen returning and charging Mental health technician] are by the arm and out the chair, seen returning and charging Mental health technician].	or and [Staff A, Mental the backpack then grabbed he resident fell."  PM, with the Director of spations, he stated: "The on 7/22/25 around 4:00 PM from another resident with technician) and on the video. [Resident#1] or the video (Resident#1] or the video (Resident#1] or the video (Resident#1] or the seated. Then [Resident#1] of the seated. Then [Resident#1] or this [Staff A, Mental health to this [Staff A, Mental health to this [Staff A, Mental health and the resident of the the resident to the technician, bulled [Resident #1] fell from At that time, ichain pulled [Resident #1] fell from At that time, ichain pulled [Resident #1] for the resident to the technician, was being to an assessment were done, chistrist were notified. The ew the video footage of the dithe footage had already being the resident of the proported it to the Abuse was reported to proported it to the Abuse was reported to proported it of the resident health on the chair [Staff A, Mental Health and Hea	FOE	600			

Facility ID: 111302

(X3) DATE SURVEY COMPLETED

CENTERS FOR MEDICARE & MEDICAID SERVICES

(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS 07/28/2025 105172 B. WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

FOUNTAIN MANOR HEALTH & REHABILITATION CENTER 390 NE 135TH ST , NORTH MIAMI, Florida, 33161 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X4) ID (X5)PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLÉTION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE DATE APPROPRIATE DEFICIENCY) Continued from page 4 FRERR On 7/29/25 at 9:22 am The Social services Director/

F0600 SS = D Abuse Coordinator revealed the investigation was concluded and the allegation of physical was abuse verified.