Florida State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1163096	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAIN MANOR HEALTH & REHABILITATION CENTER	390 NE 135TH ST , NORTH MIAMI, Florida, 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) COMPLETION DATE
N0000	INITIAL COMMENTS 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.	N0000		08/15/2025
N0204 SS = D	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, corporal punishment, extended involuntary seclusion, and physical and chemical restraints, except those restraints authorized in writing by a physician for a specified and limited period of time or as are necessitated by an emergency. In case of an emergency, restraint may be applied only by a qualified licensed nurse who shall set forth in writing the circumstances requiring the use of restraint, and, in 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: 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	N0204	Plan of Correction-Complaint Investigations for #2025010806 and 2025010894, was conducted on July 28, 2025-July 29, 2025 Citation: F600 (D/ N204-Class: III, Isolated) Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. On 07/22/2025, after reporting the incident, Resident #1 had a head to toe assessment and pain assessment completed; Medical Doctor and Psychiatrist were notified; NP ordered X-rays and no fractures were identified. The facility reported the abuse reported to Adult Protective Services (DCF), police and reported event to AHCA on 07/22/2025, in accordance with the regulations. On 07/28/2025, Staff A (Mental Health Technician) was terminated from employment. On 7/23/2025, the Risk Manager of the facility conducted in-service education for all staff members on abuse; abuse prevention (handlining difficult resident/residents with dementia or other challenging mental health diagnosis); and reporting of abuse Identification of other residents having potential to be affected by the same deficient practice and what corrective action will be taken All residents have the potential to be affected by this deficient practice. On 7/24/2025, ADON interviewed other resident to ensure to ensure that they had not been subject to abuse from Staff A or other members of facility staff. No	08/15/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1163096	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/28/2025

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N0204 SS = D	Continued from page 1 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. The findings Included: On 7/22/25 the facility submitted a federal report [] alleging Resident #1 was physically abused by Mental health technician, Staff A. On 7/28/25, The facility verified the allegation and terminated Staff A's employment. On 07/28/2025 Resident #1 was observed seated on the patio in stable condition. On 7/28/25 at 9:55 AM Resident #1 was interviewed (translated by other surveyor on the team) about the allegation and stated, "I am pleased with the staff except one person. That staff hit me, I fell to the floor, and he dragged me to my room." Record review of Resident #1's demographic sheet revealed the resident was admitted on 03/31/2025 with diagnosis that include: Dementia, psychosis, Encephalopathy, Depression, Syncope and collapse, Repeated falls, Difficulty in walking, and Osteoarthritis Record review of a Quarterly Minimum Data Set (MDS) with a reference date of 7/8/25 indicated Resident #1 is moderately impaired cognitively, had no behavior concerns, was independent for activities of daily living and required chair/bed-to-chair transfers. Record review of a care plan initiated on 5/21/25 and reviewed/revised on 7/24/25 revealed Resident #1 exhibited behaviors: spitting at staff and attempting to hit a staff member with her shoe with interventions that included: Maintain safe distance during episodes of aggression. Record review of Resident #1's Physicians Orders Sheet for March 2025 revealed orders included Memantine 5 milligrams (mg) tablet by mouth twice a day for Dementia, Escitalopram oxalate 10 mg tablet by mouth once a day for Depression, Quetiapine 25 mg tablet by mouth at bedtime for Psychosis and to monitor for agitation every shift. Record review of a Progress Note written on 7/22/25 revealed Resident #1 sustained a fall in the patio	N0204	Continued from page 1 additional complaints were identified. On 7/23/2025, the Risk Manager facility conducted in-service education for all staff members on abuse; abuse prevention (handlining difficult resident/residents with dementia or other challenging mental health diagnosis); and reporting of abuse. Measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur On 7/23/2025, the Risk Manager of the facility conducted in-service education for all staff members on abuse; abuse prevention (handlining difficult resident/residents with dementia or other challenging mental health diagnosis); and reporting of abuse. The ADON, or designee, will conduct random interviews with current residents to identify any abuse/neglect/mistreatment. No less than 10 interviews will be completed weekly x 4 weeks. Any problems identified will be investigation and an appropriate actions will be taken, as necessary. The Abuse Coordinator, or designee, will conduct random interviews with staff members on abuse, abuse prevention and reporting requirements. No less than 10 interviews will be completed weekly x 4 weeks. Any problems identified will be investigation and any appropriate actions will be implemented, as necessary. All interviews will be submitted to the ADON, or designee, weekly for evaluation of trends and any educational needs. Ongoing frequency of interviews, after the initial 4 weeks, will be determined by the QAPI and QAA Committees. Corrective action(s) will be monitored to ensure the deficient practice will not recur The findings from the interview, along with any identified trends, educational needs, and any corrective action taken as a result of the findings will be submitted Administrator, or designee, to the QA and QAPI Committees monthly for 6 months, then quarterly for 4 quarters. Correction Date: 08/15/2025	

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N0204 SS = D	Continued from page 2 area, reported pain in the left knee and right forearm, a physical assessment was performed and found on her left knee a bruise of about three centimeters(cm), and on the right arm a bruise of about one cm, the resident reported pain when bending the knee but she was able to walk, on a scale of 1 to 10 she reported that the pain 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 exam. Nurse Practitioner was called and new stat x rays order to perform right wrist, arm, and left knee received and carried out. The family was notified. Record review of the facility's Policy titled Identifying Types of Abuse Policy Statement: As part of the abuse prevention strategy, volunteers, employees and contractors hired by the facility are expected to be able to identify the different types of abuse that may occur against residents During an interview on 7/28/25 at 10:18 AM, the Unit Manager, Registered Nurse (RN) stated: "On 7/22/25, at approximately 4:00 PM while doing my rounds, a resident told me that [Resident #1] was physically abused by [Staff A, Mental Health Technician]. The resident described [Resident #1] was on the patio, placed a bag from a chair onto the floor and sat on the chair. At that time [Staff A, Mental Health Technician] pulled [Resident #1] out of the chair and [Resident #1] took an ash tray and threw it at [Staff A, Mental Health Technician]. Then [Staff A, Mental Health Technician] tried to block the ash tray by holding up the bag and pushed [Resident#1] with the bag and [Resident #1] fell on the floor. At that time [Staff A, Mental Health Technician] dragged [Resident#1] to the room. After hearing the details, I immediately reported it to The Administrator, and the cameras footage was viewed. I then I completed a full assessment on [Resident#1] on the patio and found a scrap on the Resident's right wrist and knee. There was no pain reported but the [Resident#1] was upset and was yelling. I comforted the resident at that time." On 7/28/25 at 1:57 PM The Social Services Director/ Abuse Coordinator revealed: "On 7/22/25 it was reported to me by the Administrator that a nurse reported that a resident reported to her that [Staff A, Mental health technician] was aggressive towards another resident. The administrator looked at the cameras and verified that an incident occurred and instructed me to begin the federal report. I notified the police and Department of Children and Family (DCF). The police came and DCF came and investigated. We are completing	N0204		

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N0204 SS = D	Continued from page 3 the investigation today." During an interview regarding the allegations on 7/28/25 at 2:39 PM, Staff B, DCF investigator stated "The investigation is ongoing. I spoke with [Staff A, Mental Health Technician] and discovered [Resident #1] was aggressive for the past five days and was attempting to break in the to get cigarettes and attacked [Staff A, Mental Health Technician]. I viewed video surveillance, and it showed [Staff A, Mental Health Technician] sitting on the patio and [Resident #1] threw backpack on the floor and [Staff A, Mental Health Technician] picked up the backpack then grabbed [Resident#1] and somehow the resident fell." Interview on 7/28/25 at 3:16 PM, with the Director of Nursing (DON) about the allegations; he stated: "The unit manager reported to me on 7/22/25 around 4:00 PM that an abuse allegation was from another resident between [Staff A, Mental health technician] and Resident#1]. From what I saw on the video, [Resident#1] went towards the smoking locker and grabbed a bag, threw it on the ground, and the [Staff A, Mental health technician] came from the non-smoking area and grabbed the resident's arm and snatched [Resident #1] off the chair where the resident was seated. Then [Resident#1] threw an ash tray towards [Staff A, Mental health technician] and started trying to hit [Staff A, Mental health technician]. [Staff A, Mental health technician] blocked the hits with the bag and [Resident #1] fell onto the floor in a sitting position. At that time, [Staff A, Mental health technician] pulled [Resident #1] from the ground and escorted the resident to the room. [Staff A, Mental health technician], did not report the incident. There were no other staff in the area. [Staff A, Mental health technician], was being rough and there was no need to...and it was completely unacceptable. A head-toe and pain assessment were done, and Medical Doctor and Psychiatrist were notified. The x-rays showed no fracture." The surveyor requested to view the video footage of the incident, but the DON revealed the footage had already been recorded over. Interview on 7/28/25 at 3:36 PM, the Administrator stated: "An incident of physical abuse was reported to me by The Unit Manager, I reported it to the Abuse Coordinator. At that time, I viewed the camera footage, and I saw [Resident#1] throw [Staff A, Mental health technician bookbag] and sit on the chair. [Staff A, Mental health technician] grabbed [Resident #1] roughly by the arm and out the chair. [Resident#1] was then seen returning and charging and hitting [Staff A,	N0204		

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N0204 SS = D	Continued from page 4 Mental health technician]. [Staff A, Mental health technician] used the bookbag in defense and the bookbag touched [Resident#1] in the face and the resident fell on the floor, then got up and threw an ash tray at [Staff A, Mental health technician]. [Staff A, Mental health technician] then grabbed [Resident #1] by the arm and inside. I investigated this incident by reviewing the footage and interviewing other residents, family, and staff. We concluded that the allegation was verified, and the employee was terminated on 7/28/25." On 7/29/25 at 9:22 am The Social services Director/ Abuse Coordinator revealed the investigation was concluded and the allegation of physical was abuse verified. Class III	N0204		

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F0000	INITIAL COMMENTS A complaint survey for complaint numbers 2025010806 and 2025010894, was conducted on July 28, 2025, at Fountain Manor Health & Rehabilitation Center. The facility was not in compliance with Code of Federal Regulations (CFR) 42, PART 483, Requirement for Long -Term Care Facilities.	F0000		08/15/2025
F0600 SS = D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT 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. The findings Included: On 7/22/25 the facility submitted a federal report [] alleging Resident #1 was physically abused by Mental	F0600	Plan of Correction-Complaint Investigations for #2025010806 and 2025010894, was conducted on July 28, 2025-July 29, 2025 Citation: F600 (D/ N204-Class: III, Isolated) Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. On 07/22/2025, after reporting the incident, Resident #1 had a head to toe assessment and pain assessment completed; Medical Doctor and Psychiatrist were notified; NP ordered X-rays and no fractures were identified. The facility reported the abuse reported to Adult Protective Services (OCF), police and reported event to AHCA on 07/22/2025, in accordance with the regulations. On 07/28/2025, Staff A (Mental Health Technician) was terminated from employment. On 7/23/2025, the Risk Manager of the facility conducted in-service education for all staff members on abuse; abuse prevention (handlining difficult resident/residents with dementia or other challenging mental health diagnosis); and reporting of abuse Identification of other residents having potential to be affected by the same deficient practice and what corrective action will be taken All residents have the potential to be affected by this deficient practice. On 7/24/2025, ADON interviewed other resident to ensure to ensure that they had not been subject to abuse from Staff A or other members of facility staff. No	08/15/2025

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F0600 SS = D	Continued from page 1 health technician, Staff A. On 7/28/25, The facility verified the allegation and terminated Staff A's employment. On 07/28/2025 Resident #1 was observed seated on the patio in stable condition. On 7/28/25 at 9:55 AM Resident#1 was interviewed (translated by other surveyor on the team) about the allegation and stated, "I am pleased with the staff except one person. That staff hit me, I fell to the floor, and he dragged me to my room." Record review of Resident #1's demographic sheet revealed the resident was admitted on 03/31/2025 with diagnosis that include: Dementia, psychosis, Encephalopathy, Depression, Syncope and collapse, Repeated falls, Difficulty in walking, and Osteoarthritis Record review of a Quarterly Minimum Data Set (MDS) with a reference date of 7/8/25 indicated Resident #1 is moderately impaired cognitively, had no behavior concerns, was independent for activities of daily living and required chair/bed-to-chair transfers. Record review of a care plan initiated on 5/21/25 and reviewed/revised on 7/24/25 revealed Resident #1 exhibited behaviors: spitting at staff and attempting to hit a staff member with her shoe with interventions that included: Maintain safe distance during episodes of aggression. Record review of Resident #1's Physicians Orders Sheet for March 2025 revealed orders included Memantine 5 milligrams (mg) tablet by mouth twice a day for Dementia, Escitalopram oxalate 10 mg tablet by mouth once a day for Depression, Quetiapine 25 mg tablet by mouth at bedtime for Psychosis and to monitor for agitation every shift. Record review of a Progress Note written on 7/22/25 revealed Resident #1 sustained a fall in the patio area, reported pain in the left knee and right forearm, a physical assessment was performed and found on her left knee a bruise of about three centimeters(cm), and on the right arm a bruise of about one cm, the resident reported pain when bending the knee but she was able to walk, on a scale of 1 to 10 she reported that the pain 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	F0600	Continued from page 1 additional complaints were identified. On 7/23/2025, the Risk Manager facility conducted in-service education for all staff members on abuse; abuse prevention (handlining difficult resident/residents with dementia or other challenging mental health diagnosis); and reporting of abuse. Measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur On 7/23/2025, the Risk Manager of the facility conducted in-service education for all staff members on abuse; abuse prevention (handlining difficult resident/residents with dementia or other challenging mental health diagnosis); and reporting of abuse. The ADON, or designee, will conduct random interviews with current residents to identify any abuse/neglect/mistreatment. No less than 10 interviews will be completed weekly x 4 weeks. Any problems identified will be investigation and an appropriate actions will be taken, as necessary. The Abuse Coordinator, or designee, will conduct random interviews with staff members on abuse, abuse prevention and reporting requirements. No less than 10 interviews will be completed weekly x 4 weeks. Any problems identified will be investigation and any appropriate actions will be implemented, as necessary. All interviews will be submitted to the ADON, or designee, weekly for evaluation of trends and any educational needs. Ongoing frequency of interviews, after the initial 4 weeks, will be determined by the QAPI and QAA Committees. Corrective action(s) will be monitored to ensure the deficient practice will not recur The findings from the interview, along with any identified trends, educational needs, and any corrective action taken as a result of the findings will be submitted Administrator, or designee, to the QA and QAPI Committees monthly for 6 months, then quarterly for 4 quarters. Correction Date: 08/15/2025	

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F0600 SS = D	Continued from page 2 exam. Nurse Practitioner was called and new stat x rays order to perform right wrist, arm, and left knee received and carried out. The family was notified. Record review of the facility's Policy titled Identifying Types of Abuse Policy Statement: As part of the abuse prevention strategy, volunteers, employees and contractors hired by the facility are expected to be able to identify the different types of abuse that may occur against residents During an interview on 7/28/25 at 10:18 AM, the Unit Manager, Registered Nurse (RN) stated: "On 7/22/25, at approximately 4:00 PM while doing my rounds, a resident told me that [Resident #1] was physically abused by [Staff A, Mental Health Technician]. The resident described [Resident #1] was on the patio, placed a bag from a chair onto the floor and sat on the chair. At that time [Staff A, Mental Health Technician] pulled [Resident #1] out of the chair and [Resident #1] took an ash tray and threw it at [Staff A, Mental Health Technician]. Then [Staff A, Mental Health Technician] tried to block the ash tray by holding up the bag and pushed [Resident#1] with the bag and [Resident #1] fell on the floor. At that time [Staff A, Mental Health Technician] dragged [Resident#1] to the room. After hearing the details, I immediately reported it to The Administrator, and the cameras footage was viewed. I then I completed a full assessment on [Resident#1] on the patio and found a scrap on the Resident's right wrist and knee. There was no pain reported but the [Resident#1] was upset and was yelling. I comforted the resident at that time." On 7/28/25 at 1:57 PM The Social Services Director/ Abuse Coordinator revealed: "On 7/22/25 it was reported to me by the Administrator that a nurse reported that a resident reported to her that [Staff A, Mental health technician] was aggressive towards another resident. The administrator looked at the cameras and verified that an incident occurred and instructed me to begin the federal report. I notified the police and Department of Children and Family (DCF). The police came and DCF came and investigated. We are completing the investigation today." During an interview regarding the allegations on 7/28/25 at 2:39 PM, Staff B, DCF investigator stated "The investigation is ongoing. I spoke with [Staff A, Mental Health Technician] and discovered [Resident #1] was aggressive for the past five days and was attempting to break in the to get cigarettes and attacked [Staff A, Mental Health Technician]. I viewed video surveillance, and it showed [Staff A, Mental	F0600		

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F0600 SS = D	Continued from page 3 Health Technician] sitting on the patio and [Resident #1] threw backpack on the floor and [Staff A, Mental Health Technician] picked up the backpack then grabbed [Resident#1] and somehow the resident fell." Interview on 7/28/25 at 3:16 PM, with the Director of Nursing (DON) about the allegations; he stated: "The unit manager reported to me on 7/22/25 around 4:00 PM that an abuse allegation was from another resident between [Staff A, Mental health technician] and Resident#1). From what I saw on the video, [Resident#1] went towards the smoking locker and grabbed a bag, threw it on the ground, and the [Staff A, Mental health technician] came from the non-smoking area and grabbed the resident's arm and snatched [Resident #1] off the chair where the resident was seated. Then [Resident#1] threw an ash tray towards [Staff A, Mental health technician] and started trying to hit [Staff A, Mental health technician]. [Staff A, Mental health technician] blocked the hits with the bag and [Resident #1] fell onto the floor in a sitting position. At that time, [Staff A, Mental health technician] pulled [Resident #1] from the ground and escorted the resident to the room. [Staff A, Mental health technician], did not report the incident. There were no other staff in the area. [Staff A, Mental health technician], was being rough and there was no need to...and it was completely unacceptable. A head-toe and pain assessment were done, and Medical Doctor and Psychiatrist were notified. The x-rays showed no fracture." The surveyor requested to view the video footage of the incident, but the DON revealed the footage had already been recorded over. Interview on 7/28/25 at 3:36 PM, the Administrator stated: "An incident of physical abuse was reported to me by The Unit Manager. I reported it to the Abuse Coordinator. At that time, I viewed the camera footage, and I saw [Resident#1] throw [Staff A, Mental health technician bookbag] and sit on the chair. [Staff A, Mental health technician] grabbed [Resident #1] roughly by the arm and out the chair. [Resident#1] was then seen returning and charging and hitting [Staff A, Mental health technician]. [Staff A, Mental health technician] used the bookbag in defense and the bookbag touched [Resident#1] in the face and the resident fell on the floor, then got up and threw an ash tray at [Staff A, Mental health technician]. [Staff A, Mental health technician] then grabbed [Resident #1] by the arm and inside. I investigated this incident by reviewing the footage and interviewing other residents, family, and staff. We concluded that the allegation was verified, and the employee was terminated on 7/28/25."	F0600		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAIN MANOR HEALTH & REHABILITATION CENTER	390 NE 135TH ST , NORTH MIAMI, Florida, 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) COMPLETION DATE
F0600 SS = D	Continued from page 4 On 7/29/25 at 9:22 am The Social services Director/ Abuse Coordinator revealed the investigation was concluded and the allegation of physical was abuse verified.	F0600		