STATEMENT OF DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 111329	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 3/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIAMI SHORES NURSING AND REHAB CENTER	9380 NW 7TH AVENUE MIAMI, FL

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
N 071	59A-4.109(1), FAC Components of Care Plan (1) Each resident admitted to the nursing home facility must have a plan of care. The plan of care must consist of: (a) Physician's orders, diagnosis, medical history, physical exam and rehabilitative or restorative potential. (b) A preliminary nursing evaluation with physician's orders for immediate care, completed upon admission. (c) A complete, comprehensive, accurate and reproducible assessment of each resident's functional capacity which is standardized in the facility, and is completed within 14 days of the resident's admission to the facility and every twelve months, thereafter. The assessment must be: 1. Reviewed no less than once every 3 months; 2. Reviewed promptly after a significant change, which is a need to stop a form of treatment because of adverse consequences (e.g., an adverse drug reaction), or commence a new form of treatment to deal with a problem, in the resident's physical or mental condition; and, 3. Revised as appropriate to assure the continued accuracy of the assessment. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to have an accurate Minimum Data Set (MDS) for 2 out of 32 sampled resident (Residents #24 and #89), as evidenced by two different incidents of inaccurate MDS coding. There were 96 residents residing at the facility at the time of the survey. The findings included: On at 10:52 AM, Resident #24 was coded as a Hospice Resident in Section O on the Quarterly MDS. On at 09:57 AM, Resident #89 was coded as planned, return not , discharged to a short-term general hospital (acute hospital, Inpatient prospective payment system) in Section A on the Modification of Discharge Return Not , MDS. Review of the medical records for Resident #24 revealed the resident was admitted to the facility on . Clinical diagnoses included but were not limited to: Encounter for surgical aftercare following surgery on the system. Review of the medical records for Resident #89 revealed the resident was admitted to the facility on . Clinical diagnoses included but were not limited to: Review of the Physician's Orders Sheet on revealed that Resident #24 had no hospice orders. Review of the Physician's Orders Sheet on revealed that Resident #89 had an order for Discharge to Assisted Living Facility (ALF) on . Record review of Resident #24 's MDS dated revealed: Section C for Patterns

The above deficiencies pose no actual harm to the residents

STATEMENT OF DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 111329	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 3/26/2025

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
N 071	Continued From Page 1

documented a ( ) Score of 00, on a 0-15 scale indicating the resident is . Section GG for Functional Abilities documented the resident is dependent on toileting, showering, upper and lower body .

Record review of Resident #89's MDS dated revealed: Section A for Identification Information documented a planned, return not discharge to a short-term general hospital (acute hospital, IPPS). Section B for Hearing, Speech, and Vision documented resident always needs to have someone's help when reading instructions, pamphlets, or other written material from the doctor or pharmacy. Section C for Patterns documented a Score of 00, on a 0-15 scale indicating the resident is . Section E for Behavior documented no verbal, physical or other behavioral symptoms directed towards others. Section GG for Functional Abilities documented the resident is dependent on toileting, showering, upper and lower body . Section I for Active Diagnosis documented , wasting atrophy left arm, right arm and right . Section J for Health Conditions documented no since admission. Section N for Medications documented . Section O for special treatments documented the resident is not up to date on the and .

Resident #24 does not have a care plan related to hospice.

Record review of Resident #89's Care Plans revealed the Resident can be safely discharged upon completion of the rehabilitation program as planned and as medically indicated to: ALF.

Interventions include- Assist in providing resources for transportation arrangements as needed. Consult physician regarding needs post discharge plan of care. Develop a discharge plan of care with patient and family. Assess resident for durable medical equipment (DME) needs, community resources needed and home health care services as per resident choice with doctor (MD) orders.

Interview on at 12:09 PM with Staff D, MDS Coordinator stated I communicate with nursing and social services to clarify where a resident is going after discharge and in the morning meetings. There was an oversight error. I speak to each department, including billing about the residents' discharges. To fix these issues, a modification would have to be made. Resident #24 has never been on hospice.

Interview on at 12:09 PM with Staff D, MDS Coordinator stated I communicate with nursing and social services to clarify where resident is going after discharge and in the morning meetings. There was an oversight error. I speak to each department, including billing about the residents' discharges. Resident #89 was discharged to an ALF on . To fix these issues, a modification would have to be made.

Review of the facility's policy and procedure dated regarding resident assessments states, The Resident Assessment Coordinator is responsible for ensuring that the Interdisciplinary Team conducts timely and appropriate resident assessments and reviews according to the following requirements: Omnibus Budget Reconciliation Act (OBRA) required assessments - conducted for all residents in the facility.

STATEMENT OF DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 111329	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 3/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIAMI SHORES NURSING AND REHAB CENTER	**9380 NW 7TH AVENUE MIAMI, FL**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
N 071	Continued From Page 2 Quarterly Assessment - Conducted not less frequently than three months following the most recent OBRA assessment of any type. Discharge Assessment - Conducted when a resident is discharged from the facility. Class III

STATEMENT OF DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 105449	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 3/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIAMI SHORES NURSING AND REHAB CENTER	9380 NW 7TH AVENUE MIAMI, FL

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 641	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to have an accurate Minimum Data Set (MDS) for 2 out of 32 sampled resident (Residents #24 and #89), as evidenced by two different incidents of inaccurate MDS coding. There were 96 residents residing at the facility at the time of the survey. The findings included: On at 10:52 AM, Resident #24 was coded as a Hospice Resident in Section O on the Quarterly MDS. On at 09:57 AM, Resident #89 was coded as planned, return not discharged to a short-term general hospital (acute hospital, Inpatient prospective payment system) in Section A on the Modification of Discharge Return Not MDS. Review of the medical records for Resident #24 revealed the resident was admitted to the facility on . Clinical diagnoses included but were not limited to: Encounter for surgical aftercare following surgery on the system. Review of the medical records for Resident #89 revealed the resident was admitted to the facility on . Clinical diagnoses included but were not limited to: Review of the Physician's Orders Sheet on revealed that Resident #24 had no hospice orders. Review of the Physician's Orders Sheet on revealed that Resident #89 had an order for Discharge to Assisted Living Facility (ALF) on . Record review of Resident #24 's MDS dated revealed: Section C for Patterns documented a ( ) Score of 00, on a 0-15 scale indicating the resident is . Section GG for Functional Abilities documented the resident is dependent on toileting, showering, upper and lower body . Record review of Resident #89's MDS dated revealed: Section A for Identification Information documented a planned, return not discharge to a short-term general hospital (acute hospital, IPPS). Section B for Hearing, Speech, and Vision documented resident always needs to have someone's help when reading instructions, pamphlets, or other written material from the doctor or pharmacy. Section C for Patterns documented a Score of 00, on a 0-15 scale indicating the resident is . Section E for Behavior documented no verbal, physical or other behavioral symptoms directed

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

The above deficiencies pose no actual harm to the residents

STATEMENT OF DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 105449	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 3/26/2025

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 641	Continued From Page 1

towards others. Section GG for Functional Abilities documented the resident is dependent on toileting, showering, upper and lower body . Section I for Active Diagnosis documented , , wasting atrophy left arm, right arm and right , . Section J for Health Conditions documented no since admission. Section N for Medications documented , , , , , , . Section O for special treatments documented the resident is not up to date on the and .

Resident #24 does not have a care plan related to hospice.

Record review of Resident #89's Care Plans revealed the Resident can be safely discharged upon completion of the rehabilitation program as planned and as medically indicated to: ALF.

Interventions include- Assist in providing resources for transportation arrangements as needed. Consult physician regarding needs post discharge plan of care. Develop a discharge plan of care with patient and family. Assess resident for durable medical equipment (DME) needs, community resources needed and home health care services as per resident choice with doctor (MD) orders.

Interview on at 12:09 PM with Staff D, MDS Coordinator stated I communicate with nursing and social services to clarify where a resident is going after discharge and in the morning meetings. There was an oversight error. I speak to each department, including billing about the residents' discharges. To fix these issues, a modification would have to be made. Resident #24 has never been on hospice.

Interview on at 12:09 PM with Staff D, MDS Coordinator stated I communicate with nursing and social services to clarify where resident is going after discharge and in the morning meetings. There was an oversight error. I speak to each department, including billing about the residents' discharges. Resident #89 was discharged to an ALF on . To fix these issues, a modification would have to be made.

Review of the facility's policy and procedure dated regarding resident assessments states, The Resident Assessment Coordinator is responsible for ensuring that the Interdisciplinary Team conducts timely and appropriate resident assessments and reviews according to the following requirements: Omnibus Budget Reconciliation Act (OBRA) required assessments - conducted for all residents in the facility. Quarterly Assessment - Conducted not less frequently than three months following the most recent OBRA assessment of any type. Discharge Assessment - Conducted when a resident is discharged from the facility.

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
	111329	A. BUILDING: _____ B. WING _____	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIAMI SHORES NURSING AND REHAB CENTER	9380 NW 7TH AVENUE MIAMI, FL 33150

(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 An unannounced off-hour State Licensure and Recertification survey was conducted at Miami Shores Nursing and Rehab Center on to . Deficiencies were identified at the time of survey. The following is a description of the non-compliance:	N 000		
N 054	59A-4.107(5), FAC Follow Physician Orders All physician orders must be followed as prescribed, and if not followed, the reason must be recorded on the resident's medical record during that shift. This Statute or Rule is not met as evidenced by: Based on observations, record review and interviews, the facility failed to create and implement a Restorative Care Plan for one (Resident # 43) out of one resident with a physicians order for a C-Collar. The findings included: In an observation conducted on at 06:51 AM. Revealed resident lying in bed and stated that she was feeling tired. There were no visible signs of distress or discomfort at the time of observation. Her environment appeared to be calm, and no immediate concerns were noted. Observation of resident # 43 on at 09:11 AM. The resident was observed lying in bed of bed raised, resident stated she was tired. Observation of resident # 43 on at 01:14 PM. The resident was lying in bed, speaking very disoriented.	N 054	N054 Following Phyician orders Identify patients that were at risk and what did: Patient #43. Care plans were updated accordingly, and different interventions were made. Regarding Resident #43 had the brace was added to the care plan. All other residents with similar devices were also identified and care plans verified. How will you identify other patents that are at risk:	

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		/25

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 054	Continued From page 1 Record review revealed Resident # 43 was originally admitted to the facility on . Resident #43 diagnosis included 's without dyskinesia, without mention of fluctuations Review of the physician's orders dated 23:00 Revision: revealed the resident must Keep C-collar in place at all times. Remove during care and inspect skin call MD if any abnormalities every shift. Record review of Resident # 43 Admission Minimum Data Set (MDS) Section C Pattern in the ( ) documented 00 out of 15. Section G for functional status indicated the resident needs Supervisor/Touching Assistance for activities of daily living (ADL). Review of the residents care plans revealed, there was no care plan for the use of the C-collar. Interview with Staff K, Registered Nurse (RN) on at 9:14 AM revealed upon record review that C-collar was to be always kept in place, at this moment she proceeded to have surveyor speak to restorative services for further information. Interview with , , 's Assistant (PTA) on at 09:38AM revealed that resident is not doing , , at this time, she revealed that resident is in a restorative program doing exercise. That surveyor needed to speak with someone from restorative. Interview with Staff G, Restorative Certified Nurse Assistant (CNA) on at 10:05 AM	N 054	Regarding Resident #43, the brace was added to the care plan. All other residents with similar devices were also identified and care plans.(Audit Tool) Measures put in Place: Upon admissions residents are assessed for devices. Any Devices such as braces or other devices are reviewed upon admission and reviewed in our morning meeting. During the morning meeting the MDS Coordinator will update and validate the team when this is completed. Restorative Nursing will be maintaining a weekly checklist of all new devices and will be addressed on careplan. Also, training was completed on for care plan team members regarding Floor mats, C- Collars Devices and Following Physican Orders. and nursing to communicate anytime a resident refuses treatment such as the C-Collar. This will be reported and presented to the QAPI committee to ensure compliance. How will you monitor: The Director of Nursing, MDS Coordinators, Restorative Nurse and or	

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N 054	Continued From page 2 revealed the resident was supposed to wear C-collar constantly, but that normally she doesn't like to sleep it, or wear in dining room, she also mentioned they continue to educate her of the importance of her wearing the C-collar. When surveyor asked where the C-collar is now, restorative aide revealed is in laundry, she stated the sponge is wet at the moment, but they would finish drying it and would place it on the resident. Interview with DON on at 02:14 PM revealed about the frequency of staff monitoring resident number 43, DON responded that every 2 hours, DON also mentioned resident had been participating in a prevention program. Furthermore, she stated that in Resident # 43 had a CT (Computed) scan for further evaluation, and the results were sent to the for reevaluation of the removal of C-collar and no new order was received. Record review of the facility's policy and procedure follow physician order. Date Effective date 2005/Revised 2021 under Policy: The purpose is to ensure that residents receive care and services in timely a manner when orders are given by their Physicians. Policy 1. Physician orders will be followed as prescribed. If not followed, reason will be documented in Residents medical records. Class III	N 054	Designee will be responsible for bringing the findings and summary to the QAPI Committee. Theis will occur Monthly for 3 months, then quarterly and or if any variances are reported ongoing	
N 071 SS=A	59A-4.109(1), FAC Components of Care Plan (1) Each resident admitted to the nursing home facility must have a plan of care. The plan of care	N 071		

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N 071	Continued From page 3 must consist of: (a) Physician's orders, diagnosis, medical history, physical exam and rehabilitative or restorative potential. (b) A preliminary nursing evaluation with physician's orders for immediate care, completed upon admission. (c) A complete, comprehensive, accurate and reproducible assessment of each resident's functional capacity which is standardized in the facility, and is completed within 14 days of the resident's admission to the facility and every twelve months, thereafter. The assessment must be: 1. Reviewed no less than once every 3 months; 2. Reviewed promptly after a significant change, which is a need to stop a form of treatment because of adverse consequences (e.g., an adverse drug reaction), or commence a new form of treatment to deal with a problem, in the resident's physical or mental condition; and, 3. Revised as appropriate to assure the continued accuracy of the assessment. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to have an accurate Minimum Data Set (MDS) for 2 out of 32 sampled resident (Residents #24 and #89), as evidenced by two different incidents of inaccurate MDS coding. There were 96 residents residing at the facility at the time of the survey. The findings included: On at 10:52 AM, Resident #24 was coded as a Hospice Resident in Section O on the Quarterly MDS. On at 09:57 AM, Resident #89 was	N 071		

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N 071	Continued From page 4 coded as planned, return not discharged to a short-term general hospital (acute hospital, Inpatient prospective payment system) in Section A on the Modification of Discharge Return Not MDS. Review of the medical records for Resident #24 revealed the resident was admitted to the facility on . Clinical diagnoses included but were not limited to: Encounter for surgical aftercare following surgery on the system. Review of the medical records for Resident #89 revealed the resident was admitted to the facility on . Clinical diagnoses included but were not limited to: Review of the Physician's Orders Sheet on revealed that Resident #24 had no hospice orders. Review of the Physician's Orders Sheet on revealed that Resident #89 had an order for Discharge to Assisted Living Facility (ALF) on . Record review of Resident #24 's MDS dated revealed: Section C for Patterns documented a ( ) Score of 00, on a 0-15 scale indicating the resident is Section GG for Functional Abilities documented the resident is dependent on toileting, showering, upper and lower body Record review of Resident #89's MDS dated revealed: Section A for Identification Information documented a planned, return not	N 071		

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N 071	Continued From page 5 , discharge to a short-term general hospital (acute hospital, IPPS). Section B for Hearing, Speech, and Vision documented resident always needs to have someone's help when reading instructions, pamphlets, or other written material from the doctor or pharmacy. Section C for Patterns documented a Score of 00, on a 0-15 scale indicating the resident is . Section E for Behavior documented no verbal, physical or other behavioral symptoms directed towards others. Section GG for Functional Abilities documented the resident is dependent on toileting, showering, upper and lower body . Section I for Active Diagnosis documented , wasting atrophy left arm, right arm and right . Section J for Health Conditions documented no since admission. Section N for Medications documented , . Section O for special treatments documented the resident is not up to date on the and . Resident #24 does not have a care plan related to hospice. Record review of Resident #89's Care Plans revealed the Resident can be safely discharged upon completion of the rehabilitation program as planned and as medically indicated to: ALF. Interventions include- Assist in providing resources for transportation arrangements as needed. Consult physician regarding needs post discharge plan of care. Develop a discharge plan of care with patient and family. Assess resident for durable medical equipment	N 071		

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N 071	Continued From page 6 (DME) needs, community resources needed and home health care services as per resident choice with doctor (MD) orders. Interview on at 12:09 PM with Staff D, MDS Coordinator stated I communicate with nursing and social services to clarify where a resident is going after discharge and in the morning meetings. There was an oversight error. I speak to each department, including billing about the residents' discharges. To fix these issues, a modification would have to be made. Resident #24 has never been on hospice. Interview on at 12:09 PM with Staff D, MDS Coordinator stated I communicate with nursing and social services to clarify where resident is going after discharge and in the morning meetings. There was an oversight error. I speak to each department, including billing about the residents' discharges. Resident #89 was discharged to an ALF on . To fix these issues, a modification would have to be made. Review of the facility's policy and procedure dated regarding resident assessments states, The Resident Assessment Coordinator is responsible for ensuring that the Interdisciplinary Team conducts timely and appropriate resident assessments and reviews according to the following requirements: Omnibus Budget Reconciliation Act (OBRA) required assessments - conducted for all residents in the facility. Quarterly Assessment - Conducted not less frequently than three months following the most recent OBRA assessment of any type. Discharge Assessment - Conducted when a resident is discharged from the facility.	N 071		

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N 071	Continued From page 7 Class III	N 071		
N 072 SS=D	59A-4.109(2), FAC; Comprehensive Care Plans 59A-4.109 FAC (2) The nursing home licensee develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, mental and , , needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and social well-being. The care plan must be completed within 7 days after completion of the resident assessment. This Statute or Rule is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to develop and implement comprehensive care plans for Residents #43, #74 and #291 as evidenced by no comprehensive care plan with interventions for floor mats for one resident (#291), no implementation of a care plan for one resident (#74) out of 6 residents who use floor mats and no care plan for a brace for one (#43) out of two residents who require braces. There were 96 residents residing in the facility at the time of the survey. The findings included: 1. On at 7:54 AM Resident#291 was observed in bed with one floor mat on the resident's right side, a call light was in reach.	N 072	N072-Comprehensive Care Plans Identify patients that were at risk and what did: Ref Resident #43 Regarding Resident #43 the brace with appropriate interventions was added to Care Plan. How will you identify other residents that are at risk: 100 % audit was completed to identify residents with brace. Any residents	

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(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 072	Continued From page 8 Another observation on 08:53 AM revealed floor mats were in place for Resident #291. Record review of a demographic sheet for Resident #291 revealed an admission date of with diagnoses that included: , , and Collapse, Wasting and Atrophy. Record review of an admission Minimum data set (MDS) reference dated revealed Resident #291 had a Brief Interview of Mental Status ( ) score of 9, indicated moderate , and required supervision or touching assistance for rolling left and right and partial/ for Sit to stand, transfer and walking 10 . Record review of a Care Plan initiated on and revised on revealed Resident #291 was at risk for and had no interventions pertaining to floor mats. Record review of Resident #291's current physician order sheet revealed no current orders for floor mats. On at 11:45 AM, Staff H, Registered Nurse (RN) was interviewed about how many floor mats are required for Resdient #291 and stated, "I was the nurse on Sunday and there was only one floor mat present on the Resident #291's left side because the resident usually gets out on that side of the bed." On at 1:58 PM The MDS Coordinator stated, "The floor mats had not been care planned until today for Resident #291." 2. On at 9:53 AM Resident#74 was	N 072	with brace were reviewed to ensure appropriate Care Plan was completed. Measures put in place: Upon admissions residents are assessed for devices. Any Devices such as braces or other devices are reviewed upon admission and reviewed in our morning meeting. During morning meeting the MDS Coordinator will update and validate to the team when this is completed. Restorative Nursing will be maintaining a weekly checklist of all new devices and will be addressed on care plan. Also training was completed on for care plan team members regarding Floor mats, C-Collar Devices and Following Physician Orders. Nursing staff to communicate and document anytime a resident refuses treatment such as the C-Collar to update care plan . This will be reported and presented to the QAPI committee to ensure compliance. All nursing staff were in-serviced on assistive devices (brace and floor mats). How will you monitor: The Director of Nursing, MDS Coordinators, Restorative Nurse and or Designee will be responsible for bringing the findings and summary to the QAPI Committee. This will occur Monthly for 3 months, then quarterly and or if any variances are reported ongoing	

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	111329	A. BUILDING: _____ B. WING _____	03/26/2025

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N 072	Continued From page 9 observed in bed, no distress, appears , bed low, call light in reach, one floor mat on the right side of resident. Staff N, LPN was asked how many floor mats are to be present and replied, "I will check and get to you." Record review of a demographic sheet for Resident#74 revealed an admission date of with diagnoses that included: wasting and Atrophy right upper arm, Right and Left Lower , and Difficulty in walking. Record review of a Quarterly Minimum data set (MDS) reference dated revealed Resident#74 had a Brief Interview of Mental Status ( ) of score 00, indicated severe , , , uses walker and wheelchair, required partial/ for walking and transfer. Record review of a care plan initiated on and revised on revealed Resident#74 was at risk for and had interventions that included: Provide floor mats for precautions and safety. Record review of a physician order sheet for Resident#74 revealed no orders for floor mats. Interview on at 11:02 AM Staff N, Licensed Practical Nurse (LPN) stated, "I am the nurse assigned to R#74 today. This resident is under precautions. One intervention is the floor mat on the right side of the resident because this is the side he usually tries to get up from the bed. I have observed this resident sitting on the right side of the bed. He can walk short distances with assistance and uses a wheelchair. The floor mat is used for safety precautions. This resident is to have one floor mat."	N 072	Ref Resident #74 Regarding Resident #74 the Care Plan was completed with appropriate interventions to address How will you identify other residents that are at risk: 100 % audit was completed to identify residents at risk for and Care Plan with appropriate interventions. Measures put in place: Upon admissions residents are assessed for risk. Any residents at risk for a Care Plan will be completed with appropriate interventions to address . This will be reported and presented to the QAPI committee to ensure compliance. All nursing staff were in-serviced on precautions and floor mats. How will you monitor: Through the continuous quality improvement program (Gang tackling) we will monitor compliance. The Director of Nursing, MDS Coordinators, Restorative Nurse and our Designee will be	

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N 072	Continued From page 10 On at 1:34 PM the MDS Coordinator nurse presented the surveyor with a revised care plan for at risk of with a revised intervention dated : Provide right floor mats for precautions and safety. On at 1:58 PM the MDS Coordinator stated, "I am in charge of completing and updating care plans in conjunction with the nursing staff. The Restorative nurse communicates with me for residents who require floor mats for precaution. R#74's care plan was revised today ( ) to reflect an intervention from floor mats to one floor mat on the right side. This intervention started over the weekend." On at 8:24 AM the Restorative/ care nurse stated, "Upon admission if a resident has a history of we put them in a program that includes close monitoring for 30 days, a low bed, and floor mat. The amount of floor mats are determined by the side the resident is observed trying to get out the bed without assistance. Sometimes it can be both sides. Resident #74 and #291 are not able to walk independently. We don't need a physician's order to implement floor mats. The floor mats are care planned. The floor mats were implemented for Resident #291 on the weekend due to observations by staff of Resident #291 trying to get out of bed. I told staff to place one floor mat on the side of the window. I informed MDS on Tuesday, . On at 11:44am the Director of Nursing (DON) was interviewed by the surveyor about care planning concerns for floor mats. The DON stated there is a 24 hour report in the electronic	N 072	responsible for bringing the findings and summary to the QAPI Committee. This will occur Monthly for 3 months, then quarterly and or if any variances are reported ongoing. Ref Resident #291 Regarding Resident #291 the Care Plan was completed with appropriate interventions to address floor mats. How will you identify other residents that are at risk: 100 % audit was completed to identify residents with floor mats and Care Plan in place with appropriate interventions. Measures put in place: Upon admissions residents are assessed for floor mats. Any residents found to need a floor mat a Care Plan will be completed with appropriate interventions to address . This will be reported and presented to the QAPI committee to ensure compliance. All nursing staff were in-serviced on floor mats. (risk for) How will you monitor: Through the continuous quality improvement program (Gang tackling) we	

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N 072	Continued From page 11 health record where staff can check the updated status of residents. No order is required for floor mats but should be care planned. There is also a binder kept at the nursing stations that contain residents' who require floor mats. The Restorative nurse updates that binder. Record review of a Policy titled Comprehensive Care Plans DATE: 2010 REVISED: , revealed DEPARTMENT: Nursing INTENT: It is the policy of the facility to promote seamless interdisciplinary care for our residents by utilizing the interdisciplinary plan of care based on assessment, planning, treatment, service and intervention. It is utilized to plan for and manage resident care as evidenced by documentation from admission through discharge for each resident. Every resident will have an Interdisciplinary Care Plan, with the Interim Interdisciplinary Care Plan initiated within 24 hours of admission. The care plan will identify priority problems and needs to be addressed by the interdisciplinary team, and will reflect the resident's strengths, limitations and goals. The care plan will be complete, current, realistic, time specific and appropriate to the individual needs for each resident. There will be ongoing documentation of the nursing process related to resident needs from admission to discharge. The interdisciplinary plan of care will be developed through collaborative efforts of the Interdisciplinary Team and other health care professionals. It will be consistent with the medical plan of care and those disciplines that have direct involvement with the resident's care. The resident and/or family member will be involved in the care planning. The care plan will contain information about the physical, emotional/, , , , , , spiritual, educational and environmental needs as	N 072	will monitor compliance. The Director of Nursing, MDS Coordinators, Restorative Nurse and our Designee will be responsible for bringing the findings and summary to the QAPI Committee. This will occur Monthly for 3 months, then quarterly and or if any variances are reported ongoing.	

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N 072	Continued From page 12 appropriate. Developing the Care Plan: 1. The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and , , needs that are identified in the comprehensive assessment. 2. The comprehensive care plan will describe the following: b. Any services that would otherwise be required per regulation but are not provided due to the resident's exercise of rights, including the right to refuse treatment. Updating Care Plans: 1. Care plans are modified between care plan conference when appropriate to meet the resident's current needs, problems and goals. 3. The Care Plan will be updated and/or revised for the following reasons: d. A change in planned interventions; 3) In an observation conducted on at 06:51 AM revealed, resident #43 lying in bed and stated that she was feeling tired. There were no visible signs of distress or discomfort at the time of observation. Her environment appeared to be calm, and no immediate concerns were noted. Observation of resident # 43 on at 09:11 AM. The resident was observed lying in bed the of the bed was raised, and the resident stated she was tired. Observation of resident # 43 on at 01:14 PM. The resident was lying in bed, speaking very disoriented.	N 072		

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N 072	Continued From page 13 Record review revealed Resident # 43 was originally admitted to the facility on . Resident #43 diagnoses included 's without dyskinesia, without mention of fluctuations. Review of the physician's orders dated 11:00pm Revision: revealed the resident must Keep C-collar in place at all times. Remove during care and inspect skin call MD if any abnormalities every shift. Record review of Resident # 43 Admission Minimum Data Set (MDS) Section C Pattern in the ( ) documented 00 out of 15. Section G for functional status indicated the resident needs Supervisor/Touching Assistance for activities of daily living (ADL). The facility did not have a care plan for the use of the C-collar. Interview with Staff K, Registered Nurse (RN) on at 9:14 AM revealed upon record review that the C-collar was to always kept in place, at this moment she proceeded to have the surveyor speak to restorative services for further information. Interview with the , Assistant (PTA) on at 09:38AM revealed the resident is not doing , at this time, she revealed the resident is in a restorative program doing exercise and the surveyor needed to speak with someone from restorative. Interview with Staff G, Restorative Certified Nursing Assistant (CNA) on at 10:05 AM revealed the resident was supposed to wear the C-collar constantly, but that normally she doesn't like to sleep in it, or wear it in the dining room, she also mentioned they continue to educate her	N 072		

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N 072	Continued From page 14 of the importance of her wearing the C-collar. When the surveyor asked where the C-collar is now, the restorative aide revealed it is in the laundry, she stated the sponge is wet at the moment, but they will finish drying it and would place it on the resident. Interview with DON on at 02:14 PM revealed about the frequency of staff monitoring resident # 43, the DON responded that every 2 hours, the DON also mentioned the resident had been participating in a prevention program. Furthermore, she stated that in Resident # 43 had a CT (Computed } scan for further evaluation, and the results were sent to the for reevaluation of the removal of the C-collar and no new order were received. Record review of the facility's policy and procedure to follow physicians order. Effective date 2005/Revised 2021 under Policy: The purpose is to ensure that residents receive care and services in timely a manner when orders are given by their Physicians. Policy 1. Physician orders will be followed as prescribed. If not followed, reason will be documented in Residents medical records. Class III	N 072		
N 095 SS=D	59A-4.112(6), FAC Drug Storage (6) Prescription drugs and non-prescription medications requiring refrigeration must be stored in a refrigerator. The refrigerator must be locked or located within a locked medication room and accessible only to licensed staff.	N 095		

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N 095	Continued From page 15 This Statute or Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to properly store medications as evidenced by an observation of a box of expired Rapid ␣ (Covid-19) test kits in one medication storage room and an unlocked cart (cart #1) on the west wing unit, and an unattended medication at the bedside for resident #2. The Findings included: 1) Accompanied by Staff S, an observation of the West Wing medication storage room was conducted on at 09:50 AM. The observation revealed a box with multiple expired Covid-19 test kits inside the bottom cabinet. Each Covid-19 test kit was observed with an expiration date of . Staff S, Registered Nurse (RN) supervisor confirmed the expiration date and removed a box of multiple expired Covid-19 test kits. On at 02:58 PM, Staff S stated: "The nursing supervisors are the ones in charge of monitoring and checking the medication storage room each shift. The supervisor from each shift is responsible of checking the crash cart, med room, and the pantry. When we find something or medication expired, we package it and return to pharmacy. If there is a medication that is expired in the med cart, we remove it right away and place it in the return bin for the DON (Director of Nurses) to waste it with the pharmacy. We are also supposed to place a sign on the box when it is expired, stating it cannot be used. To my understanding, a nurse cannot use a covid test without checking the expiration date first. We usually always have in-services regarding	N 095	N095 - FAC Drug Storage Identify patients that were at risk and what did: Once identified by surveyor the staff address of expired COVID Test, they were discarded. Central supply and Nursing managers educated immediately when identified by the surveyor and the Pharmacy consultant held a meeting with all nurses' about this topic on about expired medications and provided education. The nurse that left the medication cart unlocked was disciplined on . An Inservice with all nurses was done on to ensure compliance with Storage Biologicals Medications, Med Pass Administration and procedure by Pharmacist consultant. The DOH did a pharmacy audit on . How will you identify other patents that are at risk: Medication Rooms and Medication Carts were checked for expired medications once identified by surveyor. DON and Nurse management checked med carts. The pharmacy was contacted to help with Med pass Inservice and came to educate nurses on . The Inservice	

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N 095	Continued From page 16 how long we are supposed to use, for example, the lancets, , , solution for Accu-Check, covid tests, over the counter meds and where to look for the expiration date. Prior to administering medication, we are always supposed to check the expiration. We also have to label the Accu-Chek solution with the date it was opened and the date of expiration." On at 03:10 PM the Director of Nursing (DON) stated: The nursing supervisor and DON checks the medication storage rooms daily. If there are any supplies that are expired, we discard immediately. The expired covid test that you found, can still be used because there is an extended expiration date. It is stated in the FDA (Food and Drug Administration) website. The OHC (.... Healthcare) self-tests were the ones that were expired." 2) On at 7:21 AM the surveyor was walking in the hallway, and an observation was made of the an unlocked medication cart (cart #1) on the West side nursing station. Staff U, Registered Nurse (RN) approached the medication cart and was asked by the surveyor about the protocol for medication storage. Staff U, RN replied, "The medication cart should be locked when I walk away from it, but I forgot because I was moving quickly to assist residents." 3) On at 9:35 AM the Surveyor entered the room of Resident #2. Staff H, RN was observed attempting to flush a for Resient#2 to administer medication. Staff H was unable to flush the tube and told the surveyor that she would leave the room to retrieve an item to assist with the procedure. Staff H, RN exited the room. There was a cup of crushed medication	N 095	included ensuring keeping carts locked when not in use and expired meds. Measures put in Place: The supervisor that is on site will provide a new QAPI Comprehensive Supervisor Rounding tool form that spot checks rooms with Medication Administration sample. The supervisor form will be handed to DON for compliance tracking. In-service completed by Pharmacy consultant on for all nurses on expired medications and provided education. Training was also done by the Consultant pharmacist on regarding any expired testing kits and or medications. The inservice also included ensuring keeping carts locked when not in use. The DON Created new audit tolls called on -Medication Cart Audit -Treatment Cart Audit -Med room Audit	

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N 095	Continued From page 17 mixed in water on the side table and a ⌄ with a lancet on the side of the sink (photo obtained). On at 10:33 AM Staff H, RN returned and was asked by the surveyor about the protocol for leaving medications. Staff H replied, "I left the medication and ⌄ with the lancet in the room because you (surveyor) were present. The proper protocol is to take the medications and materials with me." On 11:44 AM the DON and Nursing Home Administrator were informed of the observation and stated, "The nurse didn't know she could not leave medications unattended." Record review of a Policy and Procedure titled, "Medication Storage" dated 2001 MED-PASS, Inc. (Revised ,) revealed a Policy Statement: The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. Policy Interpretation and Implementation: 2. The nursing staff shall be responsible for maintaining medication storage AND preparation areas in a clean, safe, and sanitary manner. 4. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed. 7. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others. 8. Drugs shall be stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Each resident's medications shall be assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medications of several residents.	N 095	Investigator , from the Florida Department of Health Division of Medical Quality Assurance conducted an inspection . No findings. How will you monitor: The Pharmacist will conduct a monthly audit of all medications and Carts. Nursing staff will conduct weekly audit of all medication and carts. The DON Managers and Consultant Pharmacist will be responsible for bringing the findings and summary to the QAPI Committee. This will occur Monthly for 3 months, then quarterly and or if any variances are reported ongoing.	

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N 095	Continued From page 18 Class III	N 095		
N 101 SS=D	400.141(1)(j), FS; 59A-4.118(2), FAC Resident Medical Records 400.141(1)(j) FS Keep full records of resident admissions and discharges; medical and general health status, including medical records, personal and social history, and identity and address of next of kin or other persons who may have responsibility for the affairs of the resident; and individual resident care plans, including, but not limited to, prescribed services, service frequency and duration, and service goals. The records must be open to agency inspection. The licensee shall maintain clinical records on each resident in accordance with accepted professional standards and practices, which must be complete, accurately documented, readily accessible, and systematically organized. 59A-4.118(2) FAC Each medical record must contain sufficient information to clearly identify the resident, his or her diagnosis and treatment, and results. This Statute or Rule is not met as evidenced by: Based on observation, record review and interviews, the facility failed to ensure residents' medical records are accurate in accordance with accepted professional standards and practices for one (Resident #33) out of one resident sampled, as evidenced by a Nurses' Progress Note for Resident#33 documented the resident was COVID 19 positive and the resident was COVID 19 negative. These practices has the potential to affect any of the residents residing in	N 101	N101 - FAC Resident Medical Records Identify patients that were at risk and what did: Once identified by surveyor regarding Resident #33 , the Director of Nursing contacted the LPN that erroneously documented that the patient was COVID	

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N 101	Continued From page 19 the facility. The findings included: Record review of the Charting and Documentation Policy and Procedure revised documented: Policy Statement-All services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record; Policy Interpretation and Implementation-1) All observations, medications administered, services performed must be documented in the resident's clinical record; 2) Entries may only be recorded in the resident's clinical record by licensed personnel (Registered Nurse, Licensed Practical Nurse, Physician, ,). Review of the Charting Errors and/or Omissions Policy and Procedure revised documented: Policy Statement-Accurate medical records shall be maintained by this facility; Policy Interpretation and Implementation-1) If an error is made while recording the data in the medical record, Staff member will be added to the medical record as an error. Review of the Demographic Sheet for Resident #33 documented the resident was admitted on with diagnoses that included but not limited to , , , , , , protein-calorie and atherosclerotic . Review of the Minimum Data Set (MDS) Quarterly Assessment dated for Resident #33 documented the resident's Brief Interview of Mental Status ( ) Summary Score was 00, indicating severe , and	N 101	positive when he was not and was asked to clarify the note. This was done on . How will you identify other patents that are at risk: The LPN received a 1:1 training on Accurate Documentation on . An audit was done on all remaining residents with diagnosis to ensure that the documentation was correct. Measures put in Place: An Inservice was done for all Nurses on Resident Records- Identifiable Information and Resident Accuracy was started for all nurses on , and ongoing. Example of Error identified was presented and discussed. Thereafter, DON has an ongoing QAPI Plan for incorrect documentation Audit Tool. This was started on as a weekly review.	

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	111329	A. BUILDING: _____ B. WING _____	03/26/2025

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N 101	Continued From page 20 required dependent assistance for ADLs (activities daily living). Review of the Nurses' Progress Notes for Resident #33 dated at 06:48 documented: Resident remaining in droplet/contact precaution for COVID 19 positive results using z pack in this moment . . , with positive improvement. Review of the Physician's Order Sheets (POS) and Medication Administration Records (MAR) for documented the resident was not receiving or a Z pack (,). On at 8:04 AM during an interview and record review, with the Director of Nursing (DON) it was stated, "He does not have COVID. He does not receive any such as Z pack. The progress note is inaccurate." On at 9:59 AM during an interview with Staff B, Licensed Practical Nurse (LPN) revealed that the resident is not COVID positive. Class III	N 101	How will you monitor: The DON and or designee will be responsible for bringing the findings and summary to the QAPI Committee. This will occur Monthly for 3 months, then quarterly and or if any variances are reported ongoing.	
N 110 SS=D	400.141(1)(h) FS; 59A-4.122(1) FAC Physical Environment - Safe, Clean, Homelike 400.141(1)(h) FS Maintain the facility premises and equipment and conduct its operations in a safe and sanitary manner. 59A-4.122(1) FAC The licensee must provide a safe, clean, comfortable, and homelike environment, which allows the resident to use his or her personal belongings to the extent possible	N 110		

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N 110	Continued From page 21 This Statute or Rule is not met as evidenced by: Based on observations, interviews and record review, the facility failed to provide supervision to prevent safety hazards for one resident (#2) out of 32 sampled residents as evidenced by an observation of an electrical cord plugged into an outlet suspended in the air in such a way that caused a tripping hazard in the room of Resident#2. There were 96 residents residing in the facility at the time of the survey. The findings included: On at 9:44 AM an observation was made of an electrical cord for the air mattress wrapped around the side table, extending and suspended in the air, which caused a tripping hazard in the room of Resident #2. Staff H, Registered Nurse (RN) was present in the room at the time of the observation and was notified by the surveyor of the potential tripping hazard. Staff H, RN readjusted the plug behind the bed. On at 12:18 PM the Nursing Home Administrator (NHA) was made aware by the surveyor about the tripping hazard observation and stated, "Electrical should be behind the bed and plugged into the wall unit to avoid a tripping hazard." On at 3:00 PM the NHA informed the surveyor that all plugs are now zip tied to the bed frame to prevent any tripping hazard. The NHA showed the surveyor a picture that revealed the electrical cord was zip tied around the bed frame. Record review of a demographic sheet for	N 110	N0110 - Physical Environmental-Safe Clean , Homelike Identify patients that were at risk and what did: Patient #2 bed cord was identified by surveyor and told Administrator; the director of plant operations was instructed tie all the to the frame to be removed from any potential trip hazard. Thereafter, A full house audit was completed after surveyors identified the issues on potential tripping hazards. All rooms were checked for safety on . How will you identify other patents that are at risk: A full house audit was completed after surveyors identified the issues on potential tripping hazards. All rooms were checked for safety. Staff were also Inservice on to discuss the risk of tripping hazards Measures put in Place:	

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N 110	Continued From page 22 Resident #2 revealed an admission date of and a readmission date of with diagnoses that included: Acute , Failure with , , and Covid-19. Record review of a significant change in status Minimum data set (MDS) reference dated revealed Resident#2 had a Brief Interview of Mental Status ( ) score of 12, indicating moderate , , no potential indicators of , , , was dependent on staff for Chair/bed-to-chair transfer and no since Admission/Entry or Reentry or Prior Assessment. Record review of a Care Plan initiated on and revised on revealed Resident#2 was at risk for related to Monoplegia of right dominant side, and had interventions that included: Follow facility protocol. Record review of physician order sheet revealed an order dated for Low air loss mattress in place as preventative measures and to promote healing. Check for proper functioning every shift. Record review of the policy (undated) titled, "Miami Shores Nursing and Rehabilitation Safety and Supervision of Residents: revealed a Policy Statement: Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Policy Interpretation and Implementation. Facility-Oriented Approach to Safety 4. Employees shall be trained and in serviced on potential accident hazards and how to identify and report accident hazards, and try to prevent avoidable accidents. Resident Risks and	N 110	On and Staff were inserviced on all risk and precautions and safety measures that required. Upon admission, resident rooms are assessed for room safety. The supervisor that is on site will provide a new QAPI Comprehensive Supervisor Rounding tool form that spot checks rooms with any potential trip hazards such a and any electronic charging devices. We have also added to our Gang Tackling Quality programs where scheduled rooms are checked monthly to ensure that any findings out normal are addressed immediately and reported to Management. The Forms are part of Housekeeping and Maintenance department QAPI Tracking. . Training occureed on staff were also provided with 6-point training on overall safety hazzrds and the risk associated. The supervisor form will be handed to DON for compliance tracking. How will you monitor: The DON /Maintenace and Housekeeping Supervisors will be responsible for bringing the findings and summary to the QAPI Committee. This will occur Monthly for 3 months, then quarterly and or if any variances are reported ongoing.	

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N 110	Continued From page 23 Environmental Hazards 1. Due to their and scope, certain resident risk factors and environmental hazards are addressed in dedicated policies and procedures. These risk factors and environmental hazards include: Electrical Safety. Class III	N 110		
N 201 SS=D	400.022(1)(l), FS Right to Adequate and Appropriate Health Care (l) The right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency. This Statute or Rule is not met as evidenced by: Based on observations, interviews and record review, the facility failed to provide appropriate treatment and services for care for one (Resident #2) out of one resident who has a as evidenced by observations of the tubing being kinked, and touching the floor. There were 96 residents residing in the facility at the time of the survey. The findings included: On at 9:35 AM Resident #2 was observed in bed with in progress at 2Liters per minute via a and no apparent distress was noted. A	N 201	N-201 Identify patients that were at risk and what did: Once identified by surveyor the staff addressed the issue for resident #2 the tubing being Kinked and tubing touching the floor. Thereafter, A full house audit was completed after surveyors identified the issues of cath care and rooms were checked for compliance. All rooms were	

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N 201	Continued From page 24 tubing was observed kinking in a circle and the was not properly draining (photo obtained). Staff H, Registered Nurse (RN) was present in the room and was notified by the surveyor about the kinking of the tubing. Staff H, RN then straightened out the tubing to allow free flow of . Staff H, RN was asked by the surveyor the correct way to position the tubing and Staff H stated, "I round every morning and check the tubing. This morning, I found the night nurse was working with the , so I didn't notice it was kinked." On at 7:38 AM Resident #2 was observed in bed with in progress at 2 Liters per minute via a , no apparent distress was noted. The tubing was observed touching the floor (photo obtained). On 07:42 AM Staff N, Licensed Practical Nurse (LPN) stated, "I did a double and when I rounded this morning, and I checked on Resident #2. At that time the tubing was not touching the floor. It appears the reason it was touching the floor was because someone lowered the bed too low. I round every two hours and as needed to make sure the proper interventions are in place. I communicate with the Certified Nursing Assistant (CNA) about required interventions for care and I will reinforce." On at 7:53 AM Staff P, CNA stated, "I am the CNA taking care of Resident #2 today. I have received in-services on care and the nurse speaks to me about care. I empty the collection bag and record the amount. I don't allow the collection bag to touch the floor. I also make sure it is anchored to the bed. I made	N 201	checked for safety. All nurses and CNAs were educated on on on control and the difference between Super pubic and regular . How will you identify other patents that are at risk: Thereafter, A full house audit was completed after surveyors identified the issues of care and rooms were checked for compliance. All rooms were checked for safety. All nurses and CNAs were educated on on on control and the difference between Super pubic and regular . Measures put in Place: A clinical Inservice was held on and to discuss care. The supervisor that is on site will provide a new QAPI Comprehensive Supervisor Rounding tool form that spot checks rooms with Safety as far as positioning and ensuring that it is not touching the floor. Additionally, the	

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N 201	Continued From page 25 rounds this morning and the tubing was not touching the ground and I did not lower the bed. The bed should not be too low because the tubing or bag might touch the ground for control purposes. On at 8:10 AM the Nursing educator advised the surveyor that the system was changed. Record review of a demographic sheet for Resident#2 revealed an admission date of and a readmission date of with a diagnosis that included Neuropathic . Record review of a significant change in status Minimum data set (MDS) reference dated revealed Resident#2 had a Brief Interview of Mental Status ( ) score of 12, indicated moderate , was dependent on staff for personal hygiene care, had , and . Record review of a Care Plan initiated on and revised on revealed Resident #2 had a related to and is at risk for complication with goals that included: be free of any s/s of through review date and interventions that included: Check tubing for kinks each shifts, Check bag for any leakage and change as needed. Record review of the physician order sheet revealed an order dated for care every shift and as needed, Change bag weekly every night shift every Sunday Change (16)FR every night shift	N 201	supervisor form will be handed to DON for compliance tracking. The DON created A care random audit observations checklist How will you monitor: The DON and or designee will be responsible for bringing the findings and summary to the QAPI Committee. This will occur Monthly for 3 months, then quarterly and or if any variances are reported ongoing.	

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N 201	Continued From page 26 every 1 month(s) starting on the last day of month for 1 day(s). On 01:58 PM Staff N, LPN was asked if this resident#2 has a , , ? and Staff N replied, "No." On at 2:15 PM Staff S, Nursing supervisor approached the surveyor and revealed Resdient #2 had a , , . On at 8:48 AM Staff N, LPN was reinterviewed and stated, "Resident #2 has a , , . I thought it was an , ( ) because that is what this resident had before he went out to the hospital. I didn't know it was changed to a , , . I usually only empty the collection bag. After I spoke to you, I completed a skin check and realized there was a , , in place." On at 11:44 AM the Director of Nursing (DON) was made aware of the concerns and asked about procedures and protocols when providing care and stated, "Staff are to monitor the to make sure the is draining properly, tubing is not kinked or touching the floor. Also stated, "The physician orders pertaining to care for Resident #2 should have included , , instead of , and they were updated on ." Record review of a Policy titled, " , Care written: revision date: , revealed: POLICY/PROCEDURE: The purpose of this procedure is to prevent of the resident's , tract. STEPS: 10. Secure and check drainage tubing and bag to ensure that the is draining properly.	N 201		

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N 201	Continued From page 27 Class III	N 201		
N 202 SS=D	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, interviews and record reviews, the facility failed to provide privacy for residents' information on two out of four computer screens on the East side nursing station as evidenced by an observation of an unlocked, unattended computer screen with resident information easily accessible/visible on the east side medication cart #1 and at the East side nursing station. There were 96 residents residing in the facility at the time of the survey. The findings included: 1.On at 7:39 AM, an observation was made of an unlocked, unattended computer screen on the East side medication cart #1 (photo obtained). On at 7:41 AM Staff H, Registered Nurse (RN) returned to the medication cart and was asked by the surveyor	N 202	This Plan of Correction does not constitute admission or agreement by Miami Shores Nursing & Rehabilitation Center of the truth of the facts alleged, or conclusions set forth in the statement of deficiencies. This Plan of Correction is prepared solely because it is required by State and Federal Laws. N202 Right to Privacy Identify patients that were at risk and what did: Immediately, once identified by the	

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N 202	Continued From page 28 the protocol for keeping residents' information private on computer screens and replied, "I am supposed to lock the screen before I walk away. I was worried about getting the supervisor for you, so I forgot to lock the screen." 2. On at 8:08, an observation was made of an unlocked, unattended computer screen at the East side nursing station with resident information visible (photo obtained). On at 8:09 AM Staff M, Licensed Practical Nurse (LPN) was notified by the surveyor about the observation and immediately locked the computer and locked the screen and stated another staff member left it open." Record review of an undated Policy revealed SUBJECT: Patient Privacy DIVISION: Administration DOS Risk Management Services Director DATE: Patient Privacy Policy for Nursing Homes Purpose: The purpose of this policy is to ensure the protection of patient privacy and confidentiality in accordance with applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA) and state-specific regulations. The policy to safeguard personal, medical, and financial information of residents in the nursing home, promoting trust, dignity, and respect. Scope: This policy applies to all employees, contractors, volunteers, and other personnel working in the nursing home, including those who handle patient records, communicate with patients, and interact with their families. Definitions: 1.Patient Information: All personally identifiable information (PII) and protected health information (PHI) about residents, including medical, financial, and personal details. 1. Confidentiality: The duty to protect patient information from unauthorized disclosure, access, or use. 2. Protected Health	N 202	surveyor, all Department managers were notified and asked to meet with their staff and go over HIPPA and protection of patient privacy. A facility wide Inservice was held on through /2025that reviewed HIPPA privacy and all staff were started on individual HIPPA training. The assessment completed included the issue, Root Cause Analysis and Performance improvement Plan. Staff Were trained on specific Education related to HIPPA with acknowledgement forms. Regarding the Nurse that left the computer unattended at med cart was counseled on the importance of HIPPA and protecting privacy, counseling was completed on . How will you identify other patents that are at risk? A full house audit was completed on . , to determine that no other Privacy screens were being left unattended by not only nurses but staff that use the tablets for documentation as well. Staff and Managers were remind of HIPPA Policy and Department managers	

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N 202	Continued From page 29 Information (PHI): Any information related to a patient's health condition, treatment, or payment that can be used to identify the patient. 4. Electronic Health Records (EHR): ⌄ version of a patient's medical history, including their treatment plans, medications, and , , . Policy Statement 1. Confidentiality and Privacy: a. All patient information must be treated as confidential. Unauthorized access, use, or disclosure of patient information is prohibited. b. Patient information, whether written, electronic, or verbal, should only be disclosed to individuals who have a legitimate need to know, in compliance with legal and regulatory requirements.2. Access to Patient Information: a. Only authorized personnel who require patient information to perform their duties may access PHI. b. Patient information should be stored securely, and access to records must be restricted to those with proper authorization. 4. Electronic and Paper Records: a. Electronic records must be stored in password-protected systems with encryption to prevent unauthorized access. b. Paper records containing PHI should be securely stored in locked areas, and any physical documents that are disposed of should be shredded. Class III	N 202	were tasked to keep vigilant about any screens with patient information being left unattended. Thereafter the DON created the Audit checklist to spot check for computer security during use. Measure put in place: A facility wide Inservice was held on and /2025that reviewed HIPPA privacy and all staff were started on individual HIPPA training. The assessment completed included the issue, Root Cause Analysis and Performance improvement Plan. Staff Were trained on specific Education related to HIPPA with acknowledgement forms. Training will continue upon Hire and annual review. A new system tool has been created whereby the Nurse manager that covers 24 hrs per day has a form that was developed and included the surveillance of HIPPA Compliance with all electronics including computers and tablets. The DON create an audit checklist which will be located at Nurses desk and is a daily spot checks for computer security during use. All department heads are also required to	

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N 202	Continued From page 30	N 202	monitor for the same on their daily rounds and when finding any non-compliant staff, to report to managers and provide ongoing education and progressive discipline if rules are not adhered to. We posted a sign at nurses' station and on med carts as a reminder to Lock screens before leaving long term prevention through inclusion and annual training and Orientation. How will you monitor? The DON and All department Heads are also required will use the form to track compliance. The DON and or designee will be responsible for bringing the finding and summary to the QAPI Committee. This will occur daily for 30 days, then Monthly for 3 months, then quarterly and or if any variances are reported ongoing.	

Agency for Health Care Administration

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N 000	INITIAL COMMENTS An unannounced off-hour State Licensure and Recertification survey was conducted at Miami Shores Nursing and Rehab Center on to . Deficiencies were identified at the time of survey. The following is a description of the non-compliance:	N 000		
N 054	59A-4.107(5), FAC Follow Physician Orders All physician orders must be followed as prescribed, and if not followed, the reason must be recorded on the resident's medical record during that shift. This Statute or Rule is not met as evidenced by: Based on observations, record review and interviews, the facility failed to create and implement a Restorative Care Plan for one (Resident # 43) out of one resident with a physicians order for a C-Collar. The findings included: In an observation conducted on at 06:51 AM. Revealed resident lying in bed and stated that she was feeling tired. There were no visible signs of distress or discomfort at the time of observation. Her environment appeared to be calm, and no immediate concerns were noted. Observation of resident # 43 on at 09:11 AM. The resident was observed lying in bed of bed raised, resident stated she was tired. Observation of resident # 43 on at 01:14 PM. The resident was lying in bed, speaking very disoriented.	N 054		

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	111329	A. BUILDING: _____ B. WING _____	03/26/2025

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MIAMI SHORES NURSING AND REHAB CENTER	9380 NW 7TH AVENUE MIAMI, FL 33150

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N 054	Continued From page 1 Record review revealed Resident # 43 was originally admitted to the facility on . Resident #43 diagnosis included 's without dyskinesia, without mention of fluctuations Review of the physician's orders dated 23:00 Revision: revealed the resident must Keep C-collar in place at all times. Remove during care and inspect skin call MD if any abnormalities every shift. Record review of Resident # 43 Admission Minimum Data Set (MDS) Section C Pattern in the ( ) documented 00 out of 15. Section G for functional status indicated the resident needs Supervisor/Touching Assistance for activities of daily living (ADL). Review of the residents care plans revealed, there was no care plan for the use of the C-collar. Interview with Staff K, Registered Nurse (RN) on at 9:14 AM revealed upon record review that C-collar was to be always kept in place, at this moment she proceeded to have surveyor speak to restorative services for further information. Interview with , 's Assistant (PTA) on at 09:38AM revealed that resident is not doing at this time, she revealed that resident is in a restorative program doing exercise. That surveyor needed to speak with someone from restorative. Interview with Staff G, Restorative Certified Nursing Assistant (CNA) on at 10:05 AM	N 054		

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N 054	Continued From page 2 revealed the resident was supposed to wear C-collar constantly, but that normally she doesn't like to sleep it, or wear in dining room, she also mentioned they continue to educate her of the importance of her wearing the C-collar. When surveyor asked where the C-collar is now, restorative aide revealed is in laundry, she stated the sponge is wet at the moment, but they would finish drying it and would place it on the resident. Interview with DON on at 02:14 PM revealed about the frequency of staff monitoring resident number 43, DON responded that every 2 hours, DON also mentioned resident had been participating in a prevention program. Furthermore, she stated that in Resident # 43 had a CT (Computed) scan for further evaluation, and the results were sent to the for reevaluation of the removal of C-collar and no new order was received. Record review of the facility's policy and procedure follow physician order. Date Effective date 2005/Revised 2021 under Policy: The purpose is to ensure that residents receive care and services in timely a manner when orders are given by their Physicians. Policy 1. Physician orders will be followed as prescribed. If not followed, reason will be documented in Residents medical records. Class III	N 054		
N 071 SS=A	59A-4.109(1), FAC Components of Care Plan (1) Each resident admitted to the nursing home facility must have a plan of care. The plan of care	N 071		

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N 071	Continued From page 3 must consist of: (a) Physician's orders, diagnosis, medical history, physical exam and rehabilitative or restorative potential. (b) A preliminary nursing evaluation with physician's orders for immediate care, completed upon admission. (c) A complete, comprehensive, accurate and reproducible assessment of each resident's functional capacity which is standardized in the facility, and is completed within 14 days of the resident's admission to the facility and every twelve months, thereafter. The assessment must be: 1. Reviewed no less than once every 3 months; 2. Reviewed promptly after a significant change, which is a need to stop a form of treatment because of adverse consequences (e.g., an adverse drug reaction), or commence a new form of treatment to deal with a problem, in the resident's physical or mental condition; and, 3. Revised as appropriate to assure the continued accuracy of the assessment. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to have an accurate Minimum Data Set (MDS) for 2 out of 32 sampled resident (Residents #24 and #89), as evidenced by two different incidents of inaccurate MDS coding. There were 96 residents residing at the facility at the time of the survey. The findings included: On at 10:52 AM, Resident #24 was coded as a Hospice Resident in Section O on the Quarterly MDS. On at 09:57 AM, Resident #89 was	N 071		

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N 071	Continued From page 4 coded as planned, return not , discharged to a short-term general hospital (acute hospital, Inpatient prospective payment system) in Section A on the Modification of Discharge Return Not , MDS. Review of the medical records for Resident #24 revealed the resident was admitted to the facility on . Clinical diagnoses included but were not limited to: Encounter for surgical aftercare following surgery on the system. Review of the medical records for Resident #89 revealed the resident was admitted to the facility on . Clinical diagnoses included but were not limited to: , , . Review of the Physician's Orders Sheet on revealed that Resident #24 had no hospice orders. Review of the Physician's Orders Sheet on revealed that Resident #89 had an order for Discharge to Assisted Living Facility (ALF) on . Record review of Resident #24 's MDS dated revealed: Section C for Patterns documented a ( ) Score of 00, on a 0-15 scale indicating the resident is , , , . Section GG for Functional Abilities documented the resident is dependent on toileting, showering, upper and lower body . Record review of Resident #89's MDS dated revealed: Section A for Identification Information documented a planned, return not	N 071		

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N 071	Continued From page 5 , discharge to a short-term general hospital (acute hospital, IPPS). Section B for Hearing, Speech, and Vision documented resident always needs to have someone's help when reading instructions, pamphlets, or other written material from the doctor or pharmacy. Section C for Patterns documented a Score of 00, on a 0-15 scale indicating the resident is . Section E for Behavior documented no verbal, physical or other behavioral symptoms directed towards others. Section GG for Functional Abilities documented the resident is dependent on toileting, showering, upper and lower body . Section I for Active Diagnosis documented , wasting atrophy left arm, right arm and right , . Section J for Health Conditions documented no since admission. Section N for Medications documented , . Section O for special treatments documented the resident is not up to date on the and . Resident #24 does not have a care plan related to hospice. Record review of Resident #89's Care Plans revealed the Resident can be safely discharged upon completion of the rehabilitation program as planned and as medically indicated to: ALF. Interventions include- Assist in providing resources for transportation arrangements as needed. Consult physician regarding , needs post discharge plan of care. Develop a discharge plan of care with patient and family. Assess resident for durable medical equipment	N 071		

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N 071	Continued From page 6 (DME) needs, community resources needed and home health care services as per resident choice with doctor (MD) orders. Interview on at 12:09 PM with Staff D, MDS Coordinator stated I communicate with nursing and social services to clarify where a resident is going after discharge and in the morning meetings. There was an oversight error. I speak to each department, including billing about the residents' discharges. To fix these issues, a modification would have to be made. Resident #24 has never been on hospice. Interview on at 12:09 PM with Staff D, MDS Coordinator stated I communicate with nursing and social services to clarify where resident is going after discharge and in the morning meetings. There was an oversight error. I speak to each department, including billing about the residents' discharges. Resident #89 was discharged to an ALF on . To fix these issues, a modification would have to be made. Review of the facility's policy and procedure dated regarding resident assessments states, The Resident Assessment Coordinator is responsible for ensuring that the Interdisciplinary Team conducts timely and appropriate resident assessments and reviews according to the following requirements: Omnibus Budget Reconciliation Act (OBRA) required assessments - conducted for all residents in the facility. Quarterly Assessment - Conducted not less frequently than three months following the most recent OBRA assessment of any type. Discharge Assessment - Conducted when a resident is discharged from the facility.	N 071		

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N 071	Continued From page 7 Class III	N 071		
N 072 SS=D	59A-4.109(2), FAC; Comprehensive Care Plans 59A-4.109 FAC (2) The nursing home licensee develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, mental and , , needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and social well-being. The care plan must be completed within 7 days after completion of the resident assessment. This Statute or Rule is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to develop and implement comprehensive care plans for Residents #43, #74 and #291 as evidenced by no comprehensive care plan with interventions for floor mats for one resident (#291), no implementation of a care plan for one resident (#74) out of 6 residents who use floor mats and no care plan for a brace for one (#43) out of two residents who require braces. There were 96 residents residing in the facility at the time of the survey. The findings included: 1. On at 7:54 AM Resident#291 was observed in bed with one floor mat on the resident's right side, a call light was in reach.	N 072		

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N 072	Continued From page 8 Another observation on 08:53 AM revealed floor mats were in place for Resident #291. Record review of a demographic sheet for Resident #291 revealed an admission date of with diagnoses that included: , , and Collapse, Wasting and Atrophy. Record review of an admission Minimum data set (MDS) reference dated revealed Resident #291 had a Brief Interview of Mental Status ( ) score of 9, indicated moderate , and required supervision or touching assistance for rolling left and right and partial/ for Sit to stand, transfer and walking 10 . Record review of a Care Plan initiated on and revised on revealed Resident #291 was at risk for and had no interventions pertaining to floor mats. Record review of Resident #291's current physician order sheet revealed no current orders for floor mats. On at 11:45 AM, Staff H, Registered Nurse (RN) was interviewed about how many floor mats are required for Resdient #291 and stated, "I was the nurse on Sunday and there was only one floor mat present on the Resident #291's left side because the resident usually gets out on that side of the bed." On at 1:58 PM The MDS Coordinator stated, "The floor mats had not been care planned until today for Resident #291." 2. On at 9:53 AM Resident#74 was	N 072		

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N 072	Continued From page 9 observed in bed, no distress, appears , bed low, call light in reach, one floor mat on the right side of resident. Staff N, LPN was asked how many floor mats are to be present and replied, "I will check and get to you." Record review of a demographic sheet for Resident#74 revealed an admission date of with diagnoses that included: wasting and Atrophy right upper arm, Right and Left Lower , and Difficulty in walking. Record review of a Quarterly Minimum data set (MDS) reference dated revealed Resident#74 had a Brief Interview of Mental Status ( ) of score 00, indicated severe , , , uses walker and wheelchair, required partial/ for walking and transfer. Record review of a care plan initiated on and revised on revealed Resident#74 was at risk for and had interventions that included: Provide floor mats for precautions and safety. Record review of a physician order sheet for Resident#74 revealed no orders for floor mats. Interview on at 11:02 AM Staff N, Licensed Practical Nurse (LPN) stated, "I am the nurse assigned to R#74 today. This resident is under precautions. One intervention is the floor mat on the right side of the resident because this is the side he usually tries to get up from the bed. I have observed this resident sitting on the right side of the bed. He can walk short distances with assistance and uses a wheelchair. The floor mat is used for safety precautions. This resident is to have one floor mat."	N 072		

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N 072	Continued From page 10 On at 1:34 PM the MDS Coordinator nurse presented the surveyor with a revised care plan for at risk of with a revised intervention dated : Provide right floor mats for precautions and safety. On at 1:58 PM the MDS Coordinator stated, "I am in charge of completing and updating care plans in conjunction with the nursing staff. The Restorative nurse communicates with me for residents who require floor mats for precaution. R#74's care plan was revised today ( ) to reflect an intervention from floor mats to one floor mat on the right side. This intervention started over the weekend." On at 8:24 AM the Restorative/ care nurse stated, "Upon admission if a resident has a history of we put them in a program that includes close monitoring for 30 days, a low bed, and floor mat. The amount of floor mats are determined by the side the resident is observed trying to get out the bed without assistance. Sometimes it can be both sides. Resident #74 and #291 are not able to walk independently. We don't need a physician's order to implement floor mats. The floor mats are care planned. The floor mats were implemented for Resident #291 on the weekend due to observations by staff of Resident #291 trying to get out of bed. I told staff to place one floor mat on the side of the window. I informed MDS on Tuesday, . On at 11:44am the Director of Nursing (DON) was interviewed by the surveyor about care planning concerns for floor mats. The DON stated there is a 24 hour report in the electronic	N 072		

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N 072	Continued From page 11 health record where staff can check the updated status of residents. No order is required for floor mats but should be care planned. There is also a binder kept at the nursing stations that contain residents' who require floor mats. The Restorative nurse updates that binder. Record review of a Policy titled Comprehensive Care Plans DATE: 2010 REVISED: , revealed DEPARTMENT: Nursing INTENT: It is the policy of the facility to promote seamless interdisciplinary care for our residents by utilizing the interdisciplinary plan of care based on assessment, planning, treatment, service and intervention. It is utilized to plan for and manage resident care as evidenced by documentation from admission through discharge for each resident. Every resident will have an Interdisciplinary Care Plan, with the Interim Interdisciplinary Care Plan initiated within 24 hours of admission. The care plan will identify priority problems and needs to be addressed by the interdisciplinary team, and will reflect the resident's strengths, limitations and goals. The care plan will be complete, current, realistic, time specific and appropriate to the individual needs for each resident. There will be ongoing documentation of the nursing process related to resident needs from admission to discharge. The interdisciplinary plan of care will be developed through collaborative efforts of the Interdisciplinary Team and other health care professionals. It will be consistent with the medical plan of care and those disciplines that have direct involvement with the resident's care. The resident and/or family member will be involved in the care planning. The care plan will contain information about the physical, emotional/, , , , , , spiritual, educational and environmental needs as	N 072		

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N 072	Continued From page 12 appropriate. Developing the Care Plan: 1. The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and , , needs that are identified in the comprehensive assessment. 2. The comprehensive care plan will describe the following: b. Any services that would otherwise be required per regulation but are not provided due to the resident's exercise of rights, including the right to refuse treatment. Updating Care Plans: 1. Care plans are modified between care plan conference when appropriate to meet the resident's current needs, problems and goals. 3. The Care Plan will be updated and/or revised for the following reasons: d. A change in planned interventions; 3) In an observation conducted on at 06:51 AM revealed, resident #43 lying in bed and stated that she was feeling tired. There were no visible signs of distress or discomfort at the time of observation. Her environment appeared to be calm, and no immediate concerns were noted. Observation of resident # 43 on at 09:11 AM. The resident was observed lying in bed the of the bed was raised, and the resident stated she was tired. Observation of resident # 43 on at 01:14 PM. The resident was lying in bed, speaking very disoriented.	N 072		

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N 072	Continued From page 13 Record review revealed Resident # 43 was originally admitted to the facility on . Resident #43 diagnoses included 's without dyskinesia, without mention of fluctuations. Review of the physician's orders dated 11:00pm Revision: revealed the resident must Keep C-collar in place at all times. Remove during care and inspect skin call MD if any abnormalities every shift. Record review of Resident # 43 Admission Minimum Data Set (MDS) Section C Pattern in the ( ) documented 00 out of 15. Section G for functional status indicated the resident needs Supervisor/Touching Assistance for activities of daily living (ADL). The facility did not have a care plan for the use of the C-collar. Interview with Staff K, Registered Nurse (RN) on at 9:14 AM revealed upon record review that the C-collar was to always kept in place, at this moment she proceeded to have the surveyor speak to restorative services for further information. Interview with the , , Assistant (PTA) on at 09:38AM revealed the resident is not doing , , at this time, she revealed the resident is in a restorative program doing exercise and the surveyor needed to speak with someone from restorative. Interview with Staff G, Restorative Certified Nurse Assistant (CNA) on at 10:05 AM revealed the resident was supposed to wear the C-collar constantly, but that normally she doesn't like to sleep in it, or wear it in the dining room, she also mentioned they continue to educate her	N 072		

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N 072	Continued From page 14 of the importance of her wearing the C-collar. When the surveyor asked where the C-collar is now, the restorative aide revealed it is in the laundry, she stated the sponge is wet at the moment, but they will finish drying it and would place it on the resident. Interview with DON on at 02:14 PM revealed about the frequency of staff monitoring resident # 43, the DON responded that every 2 hours, the DON also mentioned the resident had been participating in a prevention program. Furthermore, she stated that in Resident # 43 had a CT (Computed } scan for further evaluation, and the results were sent to the for reevaluation of the removal of the C-collar and no new order were received. Record review of the facility's policy and procedure to follow physicians order. Effective date 2005/Revised 2021 under Policy: The purpose is to ensure that residents receive care and services in timely a manner when orders are given by their Physicians. Policy 1. Physician orders will be followed as prescribed. If not followed, reason will be documented in Residents medical records. Class III	N 072		
N 095 SS=D	59A-4.112(6), FAC Drug Storage (6) Prescription drugs and non-prescription medications requiring refrigeration must be stored in a refrigerator. The refrigerator must be locked or located within a locked medication room and accessible only to licensed staff.	N 095		

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	111329	A. BUILDING: _____ B. WING _____	03/26/2025

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N 095	Continued From page 15 This Statute or Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to properly store medications as evidenced by an observation of a box of expired Rapid ␣ (Covid-19) test kits in one medication storage room and an unlocked cart (cart #1) on the west wing unit, and an unattended medication at the bedside for resident #2. The Findings included: 1) Accompanied by Staff S, an observation of the West Wing medication storage room was conducted on at 09:50 AM. The observation revealed a box with multiple expired Covid-19 test kits inside the bottom cabinet. Each Covid-19 test kit was observed with an expiration date of . Staff S, Registered Nurse (RN) supervisor confirmed the expiration date and removed a box of multiple expired Covid-19 test kits. On at 02:58 PM, Staff S stated: "The nursing supervisors are the ones in charge of monitoring and checking the medication storage room each shift. The supervisor from each shift is responsible of checking the crash cart, med room, and the pantry. When we find something or medication expired, we package it and return to pharmacy. If there is a medication that is expired in the med cart, we remove it right away and place it in the return bin for the DON (Director of Nurses) to waste it with the pharmacy. We are also supposed to place a sign on the box when it is expired, stating it cannot be used. To my understanding, a nurse cannot use a covid test without checking the expiration date first. We usually always have in-services regarding	N 095		

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N 095	Continued From page 16 how long we are supposed to use, for example, the lancets, , , solution for Accu-Check, covid tests, over the counter meds and where to look for the expiration date. Prior to administering medication, we are always supposed to check the expiration. We also have to label the Accu-Chek solution with the date it was opened and the date of expiration." On at 03:10 PM the Director of Nursing (DON) stated: The nursing supervisor and DON checks the medication storage rooms daily. If there are any supplies that are expired, we discard immediately. The expired covid test that you found, can still be used because there is an extended expiration date. It is stated in the FDA (Food and Drug Administration) website. The OHC (.... Healthcare) self-tests were the ones that were expired." 2) On at 7:21 AM the surveyor was walking in the hallway, and an observation was made of the an unlocked medication cart (cart #1) on the West side nursing station. Staff U, Registered Nurse (RN) approached the medication cart and was asked by the surveyor about the protocol for medication storage. Staff U, RN replied, "The medication cart should be locked when I walk away from it, but I forgot because I was moving quickly to assist residents." 3) On at 9:35 AM the Surveyor entered the room of Resident #2. Staff H, RN was observed attempting to flush a for Resient#2 to administer medication. Staff H was unable to flush the tube and told the surveyor that she would leave the room to retrieve an item to assist with the procedure. Staff H, RN exited the room. There was a cup of crushed medication	N 095		

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N 095	Continued From page 17 mixed in water on the side table and a ⌄ with a lancet on the side of the sink (photo obtained). On at 10:33 AM Staff H, RN returned and was asked by the surveyor about the protocol for leaving medications. Staff H replied, "I left the medication and ⌄ with the lancet in the room because you (surveyor) were present. The proper protocol is to take the medications and materials with me." On 11:44 AM the DON and Nursing Home Administrator were informed of the observation and stated, "The nurse didn't know she could not leave medications unattended." Record review of a Policy and Procedure titled, "Medication Storage" dated 2001 MED-PASS, Inc. (Revised ,) revealed a Policy Statement: The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. Policy Interpretation and Implementation: 2. The nursing staff shall be responsible for maintaining medication storage AND preparation areas in a clean, safe, and sanitary manner. 4. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed. 7. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others. 8. Drugs shall be stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Each resident's medications shall be assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medications of several residents.	N 095		

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N 095	Continued From page 18 Class III	N 095		
N 101 SS=D	400.141(1)(j), FS; 59A-4.118(2), FAC Resident Medical Records 400.141(1)(j) FS Keep full records of resident admissions and discharges; medical and general health status, including medical records, personal and social history, and identity and address of next of kin or other persons who may have responsibility for the affairs of the resident; and individual resident care plans, including, but not limited to, prescribed services, service frequency and duration, and service goals. The records must be open to agency inspection. The licensee shall maintain clinical records on each resident in accordance with accepted professional standards and practices, which must be complete, accurately documented, readily accessible, and systematically organized. 59A-4.118(2) FAC Each medical record must contain sufficient information to clearly identify the resident, his or her diagnosis and treatment, and results. This Statute or Rule is not met as evidenced by: Based on observation, record review and interviews, the facility failed to ensure residents' medical records are accurate in accordance with accepted professional standards and practices for one (Resident #33) out of one resident sampled, as evidenced by a Nurses' Progress Note for Resident#33 documented the resident was COVID 19 positive and the resident was COVID 19 negative. These practices has the potential to affect any of the residents residing in	N 101		

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N 101	Continued From page 19 the facility. The findings included: Record review of the Charting and Documentation Policy and Procedure revised documented: Policy Statement-All services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record; Policy Interpretation and Implementation-1) All observations, medications administered, services performed must be documented in the resident's clinical record; 2) Entries may only be recorded in the resident's clinical record by licensed personnel (Registered Nurse, Licensed Practical Nurse, Physician, ,). Review of the Charting Errors and/or Omissions Policy and Procedure revised documented: Policy Statement-Accurate medical records shall be maintained by this facility; Policy Interpretation and Implementation-1) If an error is made while recording the data in the medical record, Staff member will be added to the medical record as an error. Review of the Demographic Sheet for Resident #33 documented the resident was admitted on with diagnoses that included but not limited to , , , , , , protein-calorie and atherosclerotic . Review of the Minimum Data Set (MDS) Quarterly Assessment dated for Resident #33 documented the resident's Brief Interview of Mental Status ( ) Summary Score was 00, indicating severe , and	N 101		

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N 101	Continued From page 20 required dependent assistance for ADLs (activities daily living). Review of the Nurses' Progress Notes for Resident #33 dated at 06:48 documented: Resident remaining in droplet/contact precaution for COVID 19 positive results using z pack in this moment , with positive improvement. Review of the Physician's Order Sheets (POS) and Medication Administration Records (MAR) for documented the resident was not receiving or a Z pack (,). On at 8:04 AM during an interview and record review, with the Director of Nursing (DON) it was stated, "He does not have COVID. He does not receive any such as Z pack. The progress note is inaccurate." On at 9:59 AM during an interview with Staff B, Licensed Practical Nurse (LPN) revealed that the resident is not COVID positive. Class III	N 101		
N 110 SS=D	400.141(1)(h) FS; 59A-4.122(1) FAC Physical Environment - Safe, Clean, Homelike 400.141(1)(h) FS Maintain the facility premises and equipment and conduct its operations in a safe and sanitary manner. 59A-4.122(1) FAC The licensee must provide a safe, clean, comfortable, and homelike environment, which allows the resident to use his or her personal belongings to the extent possible	N 110		

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N 110	Continued From page 21 This Statute or Rule is not met as evidenced by: Based on observations, interviews and record review, the facility failed to provide supervision to prevent safety hazards for one resident (#2) out of 32 sampled residents as evidenced by an observation of an electrical cord plugged into an outlet suspended in the air in such a way that caused a tripping hazard in the room of Resident#2. There were 96 residents residing in the facility at the time of the survey. The findings included: On at 9:44 AM an observation was made of an electrical cord for the air mattress wrapped around the side table, extending and suspended in the air, which caused a tripping hazard in the room of Resident #2. Staff H, Registered Nurse (RN) was present in the room at the time of the observation and was notified by the surveyor of the potential tripping hazard. Staff H, RN readjusted the plug behind the bed. On at 12:18 PM the Nursing Home Administrator (NHA) was made aware by the surveyor about the tripping hazard observation and stated, "Electrical should be behind the bed and plugged into the wall unit to avoid a tripping hazard." On at 3:00 PM the NHA informed the surveyor that all plugs are now zip tied to the bed frame to prevent any tripping hazard. The NHA showed the surveyor a picture that revealed the electrical cord was zip tied around the bed frame. Record review of a demographic sheet for	N 110		

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N 110	Continued From page 22 Resident #2 revealed an admission date of and a readmission date of with diagnoses that included: Acute Failure with and Covid-19. Record review of a significant change in status Minimum data set (MDS) reference dated revealed Resident#2 had a Brief Interview of Mental Status ( ) score of 12, indicating moderate , no potential indicators of , was dependent on staff for Chair/bed-to-chair transfer and no since Admission/Entry or Reentry or Prior Assessment. Record review of a Care Plan initiated on and revised on revealed Resident#2 was at risk for related to Monoplegia of right dominant side, and had interventions that included: Follow facility protocol. Record review of physician order sheet revealed an order dated for Low air loss mattress in place as preventative measures and to promote healing. Check for proper functioning every shift. Record review of the policy (undated) titled, "Miami Shores Nursing and Rehabilitation Safety and Supervision of Residents: revealed a Policy Statement: Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Policy Interpretation and Implementation. Facility-Oriented Approach to Safety 4. Employees shall be trained and in serviced on potential accident hazards and how to identify and report accident hazards, and try to prevent avoidable accidents. Resident Risks and	N 110		

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N 110	Continued From page 23 Environmental Hazards 1. Due to their and scope, certain resident risk factors and environmental hazards are addressed in dedicated policies and procedures. These risk factors and environmental hazards include: Electrical Safety. Class III	N 110		
N 201 SS=D	400.022(1)(l), FS Right to Adequate and Appropriate Health Care (l) The right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency. This Statute or Rule is not met as evidenced by: Based on observations, interviews and record review, the facility failed to provide appropriate treatment and services for care for one (Resident #2) out of one resident who has a as evidenced by observations of the tubing being kinked, and touching the floor. There were 96 residents residing in the facility at the time of the survey. The findings included: On at 9:35 AM Resident #2 was observed in bed with in progress at 2Liters per minute via a and no apparent distress was noted. A	N 201		

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N 201	Continued From page 24 tubing was observed kinking in a circle and the was not properly draining (photo obtained). Staff H, Registered Nurse (RN) was present in the room and was notified by the surveyor about the kinking of the tubing. Staff H, RN then straightened out the tubing to allow free flow of . Staff H, RN was asked by the surveyor the correct way to position the tubing and Staff H stated, "I round every morning and check the tubing. This morning, I found the night nurse was working with the , so I didn't notice it was kinked." On at 7:38 AM Resident #2 was observed in bed with in progress at 2 Liters per minute via a , no apparent distress was noted. The tubing was observed touching the floor (photo obtained). On 07:42 AM Staff N, Licensed Practical Nurse (LPN) stated, "I did a double and when I rounded this morning, and I checked on Resident #2. At that time the tubing was not touching the floor. It appears the reason it was touching the floor was because someone lowered the bed too low. I round every two hours and as needed to make sure the proper interventions are in place. I communicate with the Certified Nursing Assistant (CNA) about required interventions for care and I will reinforce." On at 7:53 AM Staff P, CNA stated, "I am the CNA taking care of Resident #2 today. I have received in-services on care and the nurse speaks to me about care. I empty the collection bag and record the amount. I don't allow the collection bag to touch the floor. I also make sure it is anchored to the bed. I made	N 201		

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N 201	Continued From page 25 rounds this morning and the tubing was not touching the ground and I did not lower the bed. The bed should not be too low because the tubing or bag might touch the ground for control purposes. On at 8:10 AM the Nursing educator advised the surveyor that the system was changed. Record review of a demographic sheet for Resident#2 revealed an admission date of and a readmission date of with a diagnosis that included Neuropathic Record review of a significant change in status Minimum data set (MDS) reference dated revealed Resident#2 had a Brief Interview of Mental Status ( ) score of 12, indicated moderate , was dependent on staff for personal hygiene care, had , and Record review of a Care Plan initiated on and revised on revealed Resident #2 had a related to and is at risk for complication with goals that included: be free of any s/s of through review date and interventions that included: Check tubing for kinks each shifts, Check bag for any leakage and change as needed. Record review of the physician order sheet revealed an order dated for care every shift and as needed, Change bag weekly every night shift every Sunday Change (16)FR every night shift	N 201		

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N 201	Continued From page 26 every 1 month(s) starting on the last day of month for 1 day(s). On 01:58 PM Staff N, LPN was asked if this resident#2 has a , , ? and Staff N replied, "No." On at 2:15 PM Staff S, Nursing supervisor approached the surveyor and revealed Resdient #2 had a , , . On at 8:48 AM Staff N, LPN was reinterviewed and stated, "Resident #2 has a , , . I thought it was an , ( ) because that is what this resident had before he went out to the hospital. I didn't know it was changed to a , , . I usually only empty the collection bag. After I spoke to you, I completed a skin check and realized there was a , , in place." On at 11:44 AM the Director of Nursing (DON) was made aware of the concerns and asked about procedures and protocols when providing care and stated, "Staff are to monitor the to make sure the is draining properly, tubing is not kinked or touching the floor. Also stated, "The physician orders pertaining to care for Resident #2 should have included , , instead of , and they were updated on ." Record review of a Policy titled, " , Care written: revision date: , revealed: POLICY/PROCEDURE: The purpose of this procedure is to prevent of the resident's , tract. STEPS: 10. Secure and check drainage tubing and bag to ensure that the is draining properly.	N 201		

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N 201	Continued From page 27 Class III	N 201		
N 202 SS=D	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, interviews and record reviews, the facility failed to provide privacy for residents' information on two out of four computer screens on the East side nursing station as evidenced by an observation of an unlocked, unattended computer screen with resident information easily accessible/visible on the east side medication cart #1 and at the East side nursing station. There were 96 residents residing in the facility at the time of the survey. The findings included: 1.On at 7:39 AM, an observation was made of an unlocked, unattended computer screen on the East side medication cart #1 (photo obtained). On at 7:41 AM Staff H, Registered Nurse (RN) returned to the medication cart and was asked by the surveyor	N 202		

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(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 202	Continued From page 28 the protocol for keeping residents' information private on computer screens and replied, "I am supposed to lock the screen before I walk away. I was worried about getting the supervisor for you, so I forgot to lock the screen." 2. On at 8:08, an observation was made of an unlocked, unattended computer screen at the East side nursing station with resident information visible (photo obtained). On at 8:09 AM Staff M, Licensed Practical Nurse (LPN) was notified by the surveyor about the observation and immediately locked the computer and locked the screen and stated another staff member left it open." Record review of an undated Policy revealed SUBJECT: Patient Privacy DIVISION: Administration DOS Risk Management Services Director DATE: Patient Privacy Policy for Nursing Homes Purpose: The purpose of this policy is to ensure the protection of patient privacy and confidentiality in accordance with applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA) and state-specific regulations. The policy to safeguard personal, medical, and financial information of residents in the nursing home, promoting trust, dignity, and respect. Scope: This policy applies to all employees, contractors, volunteers, and other personnel working in the nursing home, including those who handle patient records, communicate with patients, and interact with their families. Definitions: 1.Patient Information: All personally identifiable information (PII) and protected health information (PHI) about residents, including medical, financial, and personal details. 1. Confidentiality: The duty to protect patient information from unauthorized disclosure, access, or use. 2. Protected Health	N 202		

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
	111329	A. BUILDING: _____ B. WING _____	03/26/2025

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N 202	Continued From page 29 Information (PHI): Any information related to a patient's health condition, treatment, or payment that can be used to identify the patient. 4. Electronic Health Records (EHR): ˬ version of a patient's medical history, including their treatment plans, medications, and , , . Policy Statement 1. Confidentiality and Privacy: a. All patient information must be treated as confidential. Unauthorized access, use, or disclosure of patient information is prohibited. b. Patient information, whether written, electronic, or verbal, should only be disclosed to individuals who have a legitimate need to know, in compliance with legal and regulatory requirements.2. Access to Patient Information: a. Only authorized personnel who require patient information to perform their duties may access PHI. b. Patient information should be stored securely, and access to records must be restricted to those with proper authorization. 4. Electronic and Paper Records: a. Electronic records must be stored in password-protected systems with encryption to prevent unauthorized access. b. Paper records containing PHI should be securely stored in locked areas, and any physical documents that are disposed of should be shredded. Class III	N 202		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105449	A. BUILDING _____ B. WING _____	03/26/2025

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F 000	INITIAL COMMENTS An unannounced off-hour recertification survey was conducted , to , at Miami Shores Nursing and Rehab Center. The facility was not in compliance with 42 CFR 483, Requirements for Long Term Care Facilities. The follwing is a description of the non-compliance:	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	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		

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 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, interviews and record reviews, the facility failed to provide privacy for residents' information on two out of four computer screens on the East side nursing station as evidenced by an observation of an unlocked, unattended computer screen with resident information easily accessible/visible on the east side medication cart #1 and at the East side nursing station. There were 96 residents residing in the facility at the time of the survey.

The findings included:

1.On at 7:39 AM, an observation was made of an unlocked, unattended computer screen on the East side medication cart #1 (photo obtained). On at 7:41 AM Staff H, Registered Nurse (RN) returned to the medication cart and was asked by the surveyor the protocol for keeping residents' information private on computer screens and replied, "I am supposed to lock the screen before I walk away. I was worried about getting the supervisor for you, so I forgot to lock the screen."

2. On at 8:08, an observation was made of an unlocked, unattended computer screen at the East side nursing station with resident information visible (photo obtained). On

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F 583	Continued From page 2	F 583		

at 8:09 AM Staff M, Licensed Practical Nurse (LPN) was notified by the surveyor about the observation and immediately locked the computer and locked the screen and stated another staff member left it open."

Record review of an undated Policy revealed SUBJECT: Patient Privacy DIVISION: Administration DOS Risk Management Services Director DATE: Patient Privacy Policy for Nursing Homes Purpose: The purpose of this policy is to ensure the protection of patient privacy and confidentiality in accordance with applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA) and state-specific regulations. The policy to safeguard personal, medical, and financial information of residents in the nursing home, promoting trust, dignity, and respect. Scope: This policy applies to all employees, contractors, volunteers, and other personnel working in the nursing home, including those who handle patient records, communicate with patients, and interact with their families. Definitions: 1.Patient Information: All personally identifiable information (PII) and protected health information (PHI) about residents, including medical, financial, and personal details. 1. Confidentiality: The duty to protect patient information from unauthorized disclosure, access, or use. 2. Protected Health Information (PHI): Any information related to a patient's health condition, treatment, or payment that can be used to identify the patient. 4. Electronic Health Records (EHR): ⌣ version of a patient's medical history, including their treatment plans, medications, and . . . Policy Statement 1. Confidentiality and Privacy: a. All patient information must be treated as confidential. Unauthorized access, use, or

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F 583	Continued From page 3 disclosure of patient information is prohibited. b. Patient information, whether written, electronic, or verbal, should only be disclosed to individuals who have a legitimate need to know, in compliance with legal and regulatory requirements.2. Access to Patient Information: a. Only authorized personnel who require patient information to perform their duties may access PHI. b. Patient information should be stored securely, and access to records must be restricted to those with proper authorization. 4. Electronic and Paper Records: a. Electronic records must be stored in password-protected systems with encryption to prevent unauthorized access. b. Paper records containing PHI should be securely stored in locked areas, and any physical documents that are disposed of should be shredded.	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 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	F 645		

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F 645	Continued From page 4	F 645		

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

§483.20(k)(3) Definition. For purposes of this

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F 645	Continued From page 5 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 observations, record review and interview, the facility failed to ensure the Preadmission Screening and Resident Review (PASARR) Level I was completed accurately prior to admission for three Residents (#50, #83, #60) out of three residents reviewed for PASARR. There were 96 residents residing in the facility at the time of the survey. The findings Included: Record review of the Pre-Admission Screening and Resident Review (PASARR) Policy and Procedure dated 2016 documented: Policy Intent-It is the policy of the facility to assure that all residents admitted to the facility receive a Pre-Admission Screening and Resident Review; Procedure-1) A facility will coordinate assessments with the pre-admission screening and resident review (PASARR) program as stated under Federal Regulations. 1) Observation of Resident #50 on at 11:07 AM revealed the resident sitting up in bed with the television on. Record review of the Demographic Sheet for Resident #50 documented the resident was	F 645		

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F 645	Continued From page 6 admitted on with diagnoses of , , , , , , , and . The resident was readmitted to the facility on . Review of the PASARR for Resident #50 revealed the PASARR Level I was done on with no diagnoses of and , checked on the form with documented history. The form documented no PASARR Level II was required. PASARR Level I was completed by a Social Worker at the hospital on . Review of the Minimum Data Set (MDS) 5 Day Assessment for Resident #50 dated documented the resident's Mental Status ( ) Summary Score had a Summary Score of 00 out of 15 indicating severe , , resident is currently not considered by the state level II PASRR process to have a SMI (Severe Mental Illness) or ID (Intellectual) or a related condition and the resident required substantial/maximal to dependent assistance for ADLs (Activities Daily Living). On at 7:30 AM, interview with the Admissions Director. She stated, "We update the PASARR, when they come here, if it is incorrect." On at 8:07 AM, interview and record review with the Director of Nursing (DON). She stated, "The PASSR was incorrect and should have included the diagnoses for and ." 2) Observation of Resident #83 on at 11:12 AM revealed the resident sitting up in bed, asleep with a , machine off	F 645		

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F 645	Continued From page 7 and with the television on. Record review of the Demographic Sheet for Resident #83 documented the resident was admitted on with diagnoses of acute , , failure, , , , , , , affective and , , . Review of the PASARR for Resident #83 revealed the PASARR Level I was done on with no diagnoses of , , , , and Affective checked on the form documented history and medications. The form documented no PASSAR Level II was required. PASARR Level I was completed by a Registered Nurse Worker at the hospital on . Review of the Minimum Data Set (MDS) Significant Change Assessment for Resident #83 dated documented the resident's Mental Status ( ) Summary Score had a Summary Score of 00 out of 15 indicating severe , , resident is currently not considered by the state level II PASARR process to have a SMI or ID or a related condition and the resident required partial/moderate to dependent assistance for ADLs (Activities Daily Living). Review of the Physician's Order Sheet (POS) for , and for Resident #83 documented the resident received , Oral Tablet 25 MG (milligrams) Give 1 tablet via at bedtime for , and Oral Tablet 10 MG Give 1 tablet via in the morning for , . Review of the Care Plans for Resident #83, written documented the resident	F 645		

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F 645	Continued From page 8 received , , medications. On at 7:54 AM, interview with the Social Services Assistant. She stated, "The Admissions Office checks the PASARRs." On at 8:08 AM, interview and record review with Director of Nursing (DON). She stated, "The PASARR was incorrect and should have included the diagnoses for , , , and Affective ." 3) On at 10:57 AM while sitting in the dining area, the surveyor overheard yelling in the hallway. The surveyor observed Resdient #60 standing in the doorway yelling. Multiple staff members were observed speaking to Resident#60 in a calm manner however Resident #60 continued to yell. Minutes later, Resident #60 agreed to sit in a chair in the doorway of the room. Record review of a demographic sheet for Resdient #60 revealed an admission date of and a readmission date of with diagnoses that included: , , , , with due to Known , , condition, . Record review of an Annual Minimum Data Set reference dated revealed A1500. Preadmission Screening and Resident Review (PASRR), Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual , or a related condition? - No. Section I revealed , , , (other than ,), Section N- , and Section O- E.	F 645		

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F 645	Continued From page 9	F 645		

, , , E1. Total minutes - record the total number of minutes this , , was administered to the resident in the last 7 days- 0.

Record review of Care Plan initiated on and revised on revealed Resident #60 was noted with physically aggressive behaviors, had a goal to demonstrate effective coping skills through the review date. (Target Date:) and interventions included: When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later and , / , consult as indicated.

Record review of a physician's order sheet revealed orders dated to monitor for side effects r/t (related to) , , med use and to Oral Tablet 50 milligrams directions: Give 1 tablet by at bedtime related to , .

Record review of a PASARR Level 1 dated revealed Section I: PASARR Screen Decision-Making A. or suspected (check all that apply): no diagnosis was checked.

The surveyor requested the most recent PASARR from the Director of Nursing (DON). The Nursing Home Administrator presented the surveyor with a PASARR for Resident #60, dated , Section I: PASARR Screen Decision- Making A. or suspected (check all that apply): no diagnosis was checked.

Interview with the Nursing Supervisor stated,

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"Resident #60 was seen by yesterday and I will complete a new PASARR." The Nursing Supervisor presented a PASRR for Resident#60, dated to Surveyor which revealed: Section I: PASRR Screen Decision- Making A. or suspected (check all that apply): was checked.

On the DON presented the Surveyor with a Progress note written by the Psychiatrist dated . The progress note revealed a diagnosis that included: .

On , the Director of Admission and the Director of Nursing were interviewed about the PASRR process. The Director of Admissions stated, "Upon admission I work with the Social workers in the hospitals prior to admission, to gather the clinicals and a completed PASARR. Sometimes the PASARRs are incomplete, and the diagnoses don't reflect the current medications the residents are taking. In this instance, I refer to the DON. The PASARR is used to make sure the resident is in the right setting due to any or mental illness. If the resident is transferred to the hospital and returns in less than 30 days it is not required to update the PASARR. When Resident #60 was admitted there was no medication for , and that is why no diagnoses were checked.

On the DON stated, "When residents are admitted I review the medications and the history to make sure it is correctly reflected on the PASARR. We review the PASARRs monthly and/or when there is a change in behavior. PASARRs are also discussed in the morning meeting and the social worker is made aware and any new changes are care planned. We also get

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F 645	Continued From page 11	F 645		

a , or psychologist consult for the resident. The PASARR for Resident #60 should have been updated at the time the , was prescribed to reflect all current mental illness diagnoses. The Psychiatrist evaluated Resident #60 yesterday ( ) due to Resident #60 exhibiting increased , and prescribed a new medication. Resident #60 is typically quiet, requires redirection and that is effective.

Record review of a Policy and Procedure titled, Subject: Pre-Admission Screening and Resident Review (PASARR) Program" revealed:
DATE: 2016
INTENT:
It is the policy of the facility to assure that all residents admitted to the facility receive a Pre-Admission Screening and Resident Review, in accordance with State and Federal Regulations.
DEFINITIONS:
For purposes of this Policy:
1. An individual is considered to have a mental if the individual has a serious mental defined in 483.102(b) (1).
2. 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.
§483.20(k)(4) A nursing facility must notify the state mental health authority or state intellectual , authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual , for resident review.
PROCEDURE:
1. A facility will coordinate assessments with the pre-admission screening and resident review

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(PASARR) program as stated under Federal Regulations to the maximum extent practicable to avoid duplicative testing and effort. Coordination
1. Incorporating the recommendations from the PASARR level II
determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.
2. Referring all level II residents and all residents with newly evident or possible serious mental , intellectual , or a related condition for level II resident review upon a significant change in status
2. The facility will not admit, on or after , any new residents with:

A. Mental , 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:
i. That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
ii. If the individual requires such level of services, whether the
individual requires specialized services; or
B. Intellectual , as unless the State intellectual or
authority has determined prior to admission:
i. That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
ii. If the individual requires such level of services, whether the individual requires specialized services for intellectual .
3. Exceptions. For purposes of this requirement

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F 645	Continued From page 13 include: 1. The preadmission screening program under paragraph(k)(1) of the regulation 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. 2. The State may choose not to apply the preadmission screening program under paragraph (k)(1) of the regulation to the admission to a nursing facility of an individual: Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, Who requires nursing facility services for the condition for which the individual received care in the hospital, and iii. Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. 4. Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If the facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.	F 645		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's	F 656		

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medical, nursing, and mental and , ,
needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and , , well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
( )In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and -informed.
This REQUIREMENT is not met as evidenced by:

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Based on observation, interviews, and record review, the facility failed to develop and implement comprehensive care plans for Residents #43, #74 and #291 as evidenced by no comprehensive care plan with interventions for floor mats for one resident (#291), no implementation of a care plan for one resident (#74) out of 6 residents who use floor mats and no care plan for a brace for one (#43) out of two residents who require braces. There were 96 residents residing in the facility at the time of the survey.

The findings included:

1. On at 7:54 AM Resident#291 was observed in bed with one floor mat on the resident's right side, a call light was in reach.

Another observation on 08:53 AM revealed floor mats were in place for Resident #291.

Record review of a demographic sheet for Resident #291 revealed an admission date of with diagnoses that included: , , and Collapse, Wasting and Atrophy.

Record review of an admission Minimum data set (MDS) reference dated revealed Resident #291 had a Brief Interview of Mental Status ( ) score of 9, indicated moderate , and required supervision or touching assistance for rolling left and right and partial/ for Sit to stand, transfer and walking 10 .

Record review of a Care Plan initiated on and revised on revealed

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Resident #291 was at risk for and had no interventions pertaining to floor mats.

Record review of Resident #291's current physician order sheet revealed no current orders for floor mats.

On at 11:45 AM, Staff H, Registered Nurse (RN) was interviewed about how many floor mats are required for Resdient #291 and stated, "I was the nurse on Sunday and there was only one floor mat present on the Resident #291's left side because the resident usually gets out on that side of the bed."

On at 1:58 PM The MDS Coordinator stated, "The floor mats had not been care planned until today for Resident #291."

2. On at 9:53 AM Resident#74 was observed in bed, no distress, appears , bed low, call light in reach, one floor mat on the right side of resident. Staff N, LPN was asked how many floor mats are to be present and replied, "I will check and get to you."

Record review of a demographic sheet for Resident#74 revealed an admission date of with diagnoses that included: wasting and Atrophy right upper arm, Right and Left Lower , and Difficulty in walking.

Record review of a Quarterly Minimum data set (MDS) reference dated revealed Resident#74 had a Brief Interview of Mental Status ( ) of score 00, indicated severe , , uses walker and wheelchair, required partial/ for walking and transfer.

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Record review of a care plan initiated on and revised on revealed Resident#74 was at risk for and had interventions that included: Provide floor mats for precautions and safety.

Record review of a physician order sheet for Resident#74 revealed no orders for floor mats.

Interview on at 11:02 AM Staff N, Licensed Practical Nurse (LPN) stated, "I am the nurse assigned to R#74 today. This resident is under precautions. One intervention is the floor mat on the right side of the resident because this is the side he usually tries to get up from the bed. I have observed this resident sitting on the right side of the bed. He can walk short distances with assistance and uses a wheelchair. The floor mat is used for safety precautions. This resident is to have one floor mat."

On at 1:34 PM the MDS Coordinator nurse presented the surveyor with a revised care plan for at risk of with a revised intervention dated : Provide right floor mats for precautions and safety.

On at 1:58 PM the MDS Coordinator stated, "I am in charge of completing and updating care plans in conjunction with the nursing staff. The Restorative nurse communicates with me for residents who require floor mats for precaution. R#74's care plan was revised today ( ) to reflect an intervention from floor mats to one floor mat on the right side. This intervention started over the weekend."

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On at 8:24 AM the Restorative/ care nurse stated, "Upon admission if a resident has a history of we put them in a program that includes close monitoring for 30 days, a low bed, and floor mat. The amount of floor mats are determined by the side the resident is observed trying to get out the bed without assistance. Sometimes it can be both sides. Resident #74 and #291 are not able to walk independently. We don't need a physician's order to implement floor mats. The floor mats are care planned. The floor mats were implemented for Resident #291 on the weekend due to observations by staff of Resident #291 trying to get out of bed. I told staff to place one floor mat on the side of the window. I informed MDS on Tuesday, .

On at 11:44am the Director of Nursing (DON) was interviewed by the surveyor about care planning concerns for floor mats. The DON stated there is a 24 hour report in the electronic health record where staff can check the updated status of residents. No order is required for floor mats but should be care planned. There is also a binder kept at the nursing stations that contain residents' who require floor mats. The Restorative nurse updates that binder.

Record review of a Policy titled Comprehensive Care Plans DATE: 2010 REVISED: , revealed DEPARTMENT: Nursing
INTENT: It is the policy of the facility to promote seamless interdisciplinary care for our residents by utilizing the interdisciplinary plan of care based on assessment, planning, treatment, service and intervention. It is utilized to plan for and manage resident care as evidenced by documentation from admission through discharge for each

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resident. Every resident will have an Interdisciplinary Care Plan, with the Interim Interdisciplinary Care Plan initiated within 24 hours of admission. The care plan will identify priority problems and needs to be addressed by the interdisciplinary team, and will reflect the resident's strengths, limitations and goals. The care plan will be complete, current, realistic, time specific and appropriate to the individual needs for each resident. There will be ongoing documentation of the nursing process related to resident needs from admission to discharge. The interdisciplinary plan of care will be developed through collaborative efforts of the Interdisciplinary Team and other health care professionals. It will be consistent with the medical plan of care and those disciplines that have direct involvement with the resident's care. The resident and/or family member will be involved in the care planning.
The care plan will contain information about the physical, emotional/, , , , , , spiritual, educational and environmental needs as appropriate.
Developing the Care Plan:
1. The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and , , needs that are identified in the comprehensive assessment.
2. The comprehensive care plan will describe the following: b. Any services that would otherwise be required per regulation but are not provided due to the resident's exercise of rights, including the right to refuse treatment.
Updating Care Plans:
1. Care plans are modified between care plan

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conference when appropriate to meet the resident's current needs, problems and goals.
3. The Care Plan will be updated and/or revised for the following reasons:

d. A change in planned interventions;

3) In an observation conducted on at 06:51 AM revealed, resident #43 lying in bed and stated that she was feeling tired. There were no visible signs of distress or discomfort at the time of observation. Her environment appeared to be calm, and no immediate concerns were noted.

Observation of resident # 43 on at 09:11 AM. The resident was observed lying in bed the of the bed was raised, and the resident stated she was tired.

Observation of resident # 43 on at 01:14 PM. The resident was lying in bed, speaking very disoriented.

Record review revealed Resident # 43 was originally admitted to the facility on . Resident #43 diagnoses included 's without dyskinesia, without mention of fluctuations.
Review of the physician's orders dated 11:00pm Revision: revealed the resident must Keep C-collar in place at all times. Remove during care and inspect skin call MD if any abnormalities every shift.

Record review of Resident # 43 Admission Minimum Data Set (MDS) Section C Pattern in the ( ) documented 00 out of 15. Section G for functional status indicated the resident needs

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Supervisor/Touching Assistance for activities of daily living (ADL). The facility did not have a care plan for the use of the C-collar.

Interview with Staff K, Registered Nurse (RN) on at 9:14 AM revealed upon record review that the C-collar was to always kept in place, at this moment she proceeded to have the surveyor speak to restorative services for further information.

Interview with the , , Assistant (PTA) on at 09:38AM revealed the resident is not doing , , at this time, she revealed the resident is in a restorative program doing exercise and the surveyor needed to speak with someone from restorative.

Interview with Staff G, Restorative Certified Nursing Assistant (CNA) on at 10:05 AM revealed the resident was supposed to wear the C-collar constantly, but that normally she doesn't like to sleep in it, or wear it in the dining room, she also mentioned they continue to educate her of the importance of her wearing the C-collar. When the surveyor asked where the C-collar is now, the restorative aide revealed it is in the laundry, she stated the sponge is wet at the moment, but they will finish drying it and would place it on the resident.

Interview with DON on at 02:14 PM revealed about the frequency of staff monitoring resident # 43, the DON responded that every 2 hours, the DON also mentioned the resident had been participating in a prevention program. Furthermore, she stated that in Resident # 43 had a CT (Computed , ,) scan for further evaluation, and the results were

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F 656	Continued From page 22 sent to the ⌄ for reevaluation of the removal of the C-collar and no new order were received. Record review of the facility's policy and procedure to follow physicians order. Effective date 2005/Revised 2021 under Policy: The purpose is to ensure that residents receive care and services in timely a manner when orders are given by their Physicians. Policy 1. Physician orders will be followed as prescribed. If not followed, reason will be documented in Residents medical records.	F 656		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, the facility failed to provide supervision to prevent safety hazards for one resident (#2) out of 32 sampled residents as evidenced by an observation of an electrical cord plugged into an outlet suspended in the air in such a way that caused a tripping hazard in the room of Resident#2. There were 96 residents residing in the facility at the time of the survey. The findings included:	F 689		

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On at 9:44 AM an observation was made of an electrical cord for the air mattress wrapped around the side table, extending and suspended in the air, which caused a tripping hazard in the room of Resident #2. Staff H, Registered Nurse (RN) was present in the room at the time of the observation and was notified by the surveyor of the potential tripping hazard. Staff H, RN readjusted the plug behind the bed.

On at 12:18 PM the Nursing Home Administrator (NHA) was made aware by the surveyor about the tripping hazard observation and stated, "Electrical should be behind the bed and plugged into the wall unit to avoid a tripping hazard."

On at 3:00 PM the NHA informed the surveyor that all plugs are now zip tied to the bed frame to prevent any tripping hazard. The NHA showed the surveyor a picture that revealed the electrical cord was zip tied around the bed frame.

Record review of a demographic sheet for Resident #2 revealed an admission date of and a readmission date of with diagnoses that included: Acute , Failure with , and Covid-19.

Record review of a significant change in status Minimum data set (MDS) reference dated revealed Resident#2 had a Brief Interview of Mental Status ( ) score of 12, indicating moderate , no potential indicators of , was dependent on staff for Chair/bed-to-chair transfer and no since Admission/Entry or Reentry or Prior Assessment.

Record review of a Care Plan initiated on

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F 689	Continued From page 24 and revised on revealed Resident#2 was at risk for related to Monoplegia of right dominant side, and had interventions that included: Follow facility protocol. Record review of physician order sheet revealed an order dated for Low air loss mattress in place as preventative measures and to promote healing. Check for proper functioning every shift. Record review of the policy (undated) titled, "Miami Shores Nursing and Rehabilitation Safety and Supervision of Residents: revealed a Policy Statement: Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Policy Interpretation and Implementation. Facility-Oriented Approach to Safety 4. Employees shall be trained and in serviced on potential accident hazards and how to identify and report accident hazards, and try to prevent avoidable accidents. Resident Risks and Environmental Hazards 1. Due to their , and scope, certain resident risk factors and environmental hazards are addressed in dedicated policies and procedures. These risk factors and environmental hazards include: Electrical Safety.	F 689		
F 690 SS=D	/ , , CFR(s): 483.25(e)(1)-(3) §483.25(e) §483.25(e)(1) The facility must ensure that resident who is of and on admission receives services and assistance to	F 690		

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maintain unless his or her clinical condition is or becomes such that is not possible to maintain.

§483.25(e)(2)For a resident with , based on the resident's comprehensive assessment, the facility must ensure that-
(i) A resident who enters the facility without an is not unless the resident's clinical condition demonstrates that was necessary;
(ii) A resident who enters the facility with an or subsequently receives one is assessed for removal of the as soon as possible unless the resident's clinical condition demonstrates that is necessary; and
(iii) A resident who is of receives appropriate treatment and services to prevent and to restore to the extent possible.

§483.25(e)(3) For a resident with fecal , based on the resident's comprehensive assessment, the facility must ensure that a resident who is of receives appropriate treatment and services to restore as much normal function as possible.
This REQUIREMENT is not met as evidenced by:
Based on observations, interviews and record review, the facility failed to provide appropriate treatment and services for care for one (Resident #2) out of one resident who has a , as evidenced by observations of the tubing being kinked, and touching the floor. There were 96

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(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
F 690	Continued From page 26 residents residing in the facility at the time of the survey. The findings included: On at 9:35 AM Resident #2 was observed in bed with in progress at 2Liters per minute via a and no apparent distress was noted. A tubing was observed kinking in a circle and the was not properly draining (photo obtained). Staff H, Registered Nurse (RN) was present in the room and was notified by the surveyor about the kinking of the tubing. Staff H, RN then straightened out the tubing to allow free flow of . Staff H, RN was asked by the surveyor the correct way to position the tubing and Staff H stated, "I round every morning and check the tubing. This morning, I found the night nurse was working with the so I didn't notice it was kinked." On at 7:38 AM Resident #2 was observed in bed with in progress at 2 Liters per minute via a , no apparent distress was noted. The tubing was observed touching the floor (photo obtained). On 07:42 AM Staff N, Licensed Practical Nurse (LPN) stated, "I did a double and when I rounded this morning, and I checked on Resident #2. At that time the tubing was not touching the floor. It appears the reason it was touching the floor was because someone lowered the bed too low. I round every two hours and as needed to make sure the proper interventions are in place. I communicate with the Certified Nursing Assistant (CNA) about required	F 690		

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F 690	Continued From page 27 interventions for care and I will reinforce." On at 7:53 AM Staff P, CNA stated, "I am the CNA taking care of Resident #2 today. I have received in-services on care and the nurse speaks to me about care. I empty the collection bag and record the amount. I don't allow the collection bag to touch the floor. I also make sure it is anchored to the bed. I made rounds this morning and the tubing was not touching the ground and I did not lower the bed. The bed should not be too low because the tubing or bag might touch the ground for control purposes. On at 8:10 AM the Nursing educator advised the surveyor that the system was changed. Record review of a demographic sheet for Resident#2 revealed an admission date of and a readmission date of with a diagnosis that included Neuropathic Record review of a significant change in status Minimum data set (MDS) reference dated revealed Resident#2 had a Brief Interview of Mental Status ( ) score of 12, indicated moderate , was dependent on staff for personal hygiene care, had , and Record review of a Care Plan initiated on and revised on revealed Resident #2 had a related to , and is at risk for	F 690		

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complication with goals that included: be free of any s/s of through review date and interventions that included: Check tubing for kinks each shifts, Check bag for any leakage and change as needed.

Record review of the physician order sheet revealed an order dated for care every shift and as needed, Change bag weekly every night shift every Sunday Change (16)FR every night shift every 1 month(s) starting on the last day of month for 1 day(s).

On 01:58 PM Staff N, LPN was asked if this resident#2 has a ? and Staff N replied, "No."
On at 2:15 PM Staff S, Nursing supervisor approached the surveyor and revealed Resdient #2 had a .

On at 8:48 AM Staff N, LPN was reinterviewed and stated, "Resident #2 has a . I thought it was an ( ) because that is what this resident had before he went out to the hospital. I didn't know it was changed to a . I usually only empty the collection bag. After I spoke to you, I completed a skin check and realized there was a in place."

On at 11:44 AM the Director of Nursing (DON) was made aware of the concerns and asked about procedures and protocols when providing care and stated, "Staff are to monitor the to make sure the is draining properly, tubing is not kinked or touching the floor. Also stated, "The physician

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F 690	Continued From page 29 orders pertaining to care for Resident #2 should have included , , instead of , and they were updated on ." Record review of a Policy titled, " Care written: revision date: revealed: POLICY/PROCEDURE: The purpose of this procedure is to prevent of the resident's , tract. STEPS: 10. Secure and check drainage tubing and bag to ensure that the is draining properly.	F 690		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Prevention and Control Act of 1976 and other drugs subject to , except when the facility uses single unit package drug distribution systems in which the	F 761		

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quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to properly store medications as evidenced by an observation of a box of expired Rapid (Covid-19) test kits in one medication storage room and an unlocked cart (cart #1) on the west wing unit, and an unattended medication at the bedside for resident #2.

The Findings included:

1) Accompanied by Staff S, an observation of the West Wing medication storage room was conducted on at 09:50 AM. The observation revealed a box with multiple expired Covid-19 test kits inside the bottom cabinet. Each Covid-19 test kit was observed with an expiration date of . Staff S, Registered Nurse (RN) supervisor confirmed the expiration date and removed a box of multiple expired Covid-19 test kits.

On at 02:58 PM, Staff S stated: "The nursing supervisors are the ones in charge of monitoring and checking the medication storage room each shift. The supervisor from each shift is responsible of checking the crash cart, med room, and the pantry. When we find something or medication expired, we package it and return to pharmacy. If there is a medication that is expired in the med cart, we remove it right away and place it in the return bin for the DON (Director of Nurses) to waste it with the pharmacy. We are also supposed to place a sign on the box when it is expired, stating it cannot be used. To my

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understanding, a nurse cannot use a covid test without checking the expiration date first. We usually always have in-services regarding how long we are supposed to use, for example, the lancets, , , solution for Accu-Check, covid tests, over the counter meds and where to look for the expiration date. Prior to administering medication, we are always supposed to check the expiration. We also have to label the Accu-Chek solution with the date it was opened and the date of expiration."

On at 03:10 PM the Director of Nursing (DON) stated: The nursing supervisor and DON checks the medication storage rooms daily. If there are any supplies that are expired, we discard immediately. The expired covid test that you found, can still be used because there is an extended expiration date. It is stated in the FDA (Food and Drug Administration) website. The OHC (.... Healthcare) self-tests were the ones that were expired."

2) On at 7:21 AM the surveyor was walking in the hallway, and an observation was made of the an unlocked medication cart (cart #1) on the West side nursing station. Staff U, Registered Nurse (RN) approached the medication cart and was asked by the surveyor about the protocol for medication storage. Staff U, RN replied, "The medication cart should be locked when I walk away from it, but I forgot because I was moving quickly to assist residents."

3) On at 9:35 AM the Surveyor entered the room of Resident #2. Staff H, RN was observed attempting to flush a for

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Resient#2 to administer medication. Staff H was unable to flush the tube and told the surveyor that she would leave the room to retrieve an item to assist with the procedure. Staff H, RN exited the room. There was a cup of crushed medication mixed in water on the side table and a ⌄ with a lancet on the side of the sink (photo obtained). On at 10:33 AM Staff H, RN returned and was asked by the surveyor about the protocol for leaving medications. Staff H replied, "I left the medication and ⌄ with the lancet in the room because you (surveyor) were present. The proper protocol is to take the medications and materials with me."

On 11:44 AM the DON and Nursing Home Administrator were informed of the observation and stated, "The nurse didn't know she could not leave medications unattended."

Record review of a Policy and Procedure titled, "Medication Storage" dated 2001 MED-PASS, Inc. (Revised ,) revealed a Policy Statement: The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. Policy Interpretation and Implementation: 2. The nursing staff shall be responsible for maintaining medication storage AND preparation areas in a clean, safe, and sanitary manner. 4. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed. 7. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others. 8. Drugs shall be

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F 761	Continued From page 33 stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Each resident's medications shall be assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medications of several residents.	F 761		
F 814 SS=D	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the facility failed to assure cardboard boxes were properly disposed and contained on the facility grounds. Cardboard boxes were scattered on the ground outside the kitchen door. The findings included: Record review of the Food-Related Garbage and Rubbish Disposal Policy and Procedure revised documented: Policy Statement-Food-related garbage and rubbish shall be disposed of in accordance with current state laws regulating such matters; Policy Interpretation and Implementation-4) Food storage boxes/containers will be disposed of by the end of each shift into the outside dumpsters. Observation of the outside of the facility at the kitchen door with the Dietary Aide A on at 7:01 AM. There were multiple cardboard boxes on the ground and not contained in the garbage bin. Photographic evidence submitted.	F 814		

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F 814	Continued From page 34 On at 7:03 AM, interview with Staff A, Dietary Aide. She stated, "Someone is supposed to break down the cardboard boxes and take them to the garbage container. They should not be on the ground." On at 8:27 AM, interview with the Dietary Director. He revealed that the carboard boxes were removed from the ground outside of the kitchen door and should not have been on the ground.	F 814		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and ( ) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the	F 842		

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records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
( ) For public health activities, reporting of , neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(h)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(h)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
( ) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and

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F 842	Continued From page 36 (vi) Laboratory, , and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews, the facility failed to ensure residents' medical records are accurate in accordance with accepted professional standards and practices for one (Resident #33) out of one resident sampled, as evidenced by a Nurses' Progress Note for Resident#33 documented the resident was COVID 19 positive and the resident was COVID 19 negative. These practices has the potential to affect any of the residents residing in the facility. The findings included: Record review of the Charting and Documentation Policy and Procedure revised documented: Policy Statement-All services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record; Policy Interpretation and Implementation-1) All observations, medications administered, services performed must be documented in the resident's clinical record; 2) Entries may only be recorded in the resident's clinical record by licensed personnel (Registered Nurse, Licensed Practical Nurse, Physician, ,). Review of the Charting Errors and/or Omissions Policy and Procedure revised documented: Policy Statement-Accurate medical records shall be maintained by this facility; Policy Interpretation and Implementation-1) If an error is made while recording the data in the medical record, Staff member will be added to the medical	F 842		

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F 842	Continued From page 37 record as an error. Review of the Demographic Sheet for Resident #33 documented the resident was admitted on with diagnoses that included but not limited to , protein-calorie and atherosclerotic . Review of the Minimum Data Set (MDS) Quarterly Assessment dated for Resident #33 documented the resident's Brief Interview of Mental Status ( ) Summary Score was 00, indicating severe and required dependent assistance for ADLs (activities daily living). Review of the Nurses' Progress Notes for Resident #33 dated at 06:48 documented: Resident remaining in droplet/contact precaution for COVID 19 positive results using z pack in this moment with positive improvement. Review of the Physician's Order Sheets (POS) and Medication Administration Records (MAR) for documented the resident was not receiving or a Z pack ( ). On at 8:04 AM during an interview and record review, with the Director of Nursing (DON) it was stated, "He does not have COVID. He does not receive any such as Z pack. The progress note is inaccurate." On at 9:59 AM during an interview with Staff B, Licensed Practical Nurse (LPN) revealed that the resident is not COVID positive.	F 842		

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F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii)	F 867		

§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 [redacted] 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, analyze and use data and information relating to adverse events in the facility, including how the

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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 activities must track medical errors and adverse resident events, analyze their causes, and

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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 interview and record review, the facility failed to demonstrate effective plans of actions were implemented to correctly identify quality

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deficiencies in the problem area related to repeated deficient practices for F880 Prevention & Control, as evidenced by the control protocol was not followed on the east side soiled utility room and failed to follow control protocol for one Resident # 57, as evidenced by a failure to implement hygiene. There were 96 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 survey with exit dated , F880 Prevention & Control was cited related to the fact that the facility failed to implement control procedures for three (Residents 89, 347, 348) out of 28 sampled residents.

Interview with the Director of Nursing (DON) on at 03:44 PM. She stated that the Quality Assurance and Performance Improvement (QAPI) meetings are held each month. She stated that QAPI committee members are Medical Director, Administrator, Director of Nursing, Social Services, Business Office Manager, Dietary, MDS (Minimum Data Set), and Care. She stated that they have daily meetings, and monthly recap meetings. They started reviewing the last meeting and focusing on the deficiencies the facility had in the last survey. She stated the way they monitor Quality Assurance is to continuously communicate with the different departments and make sure we track the corrective actions implemented. They also provide in-service education and regular performance review. She said staff addresses any concerns to their

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F 867	Continued From page 42 supervisor. Residents with ⌄ issue get ⌄ weekly, if residents are not eating they have a team put a plan into place. When asked about staffing, she revealed they met the state requirements and they have increased supervision 7:00am-7:00pm. Record review of Quality Assurance/Quality Assurance Performance Improvement QAPI/QAA Goals/Purpose Statement: Our purpose is to provide excellent quality resident/patient care and services. Quality is defined as meeting or exceeding the needs, expectations and requirements of the patients cost-effectively while maintaining good resident/patient outcomes and perceptions of patient care. [...] has a Performance Improvement Program which systematically monitors, analyses and improves its performance to improve resident/ patient outcomes. It recognizes that the value in healthcare is the appropriate balance between good measures, excellent care and services and cost. We will monitor our operations for compliance with federal and state regulations.	F 867		
F 880 SS=E	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	F 880		

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F 880	Continued From page 43 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. (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	F 880		

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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 interviews, the facility failed to follow their control protocol in the East side soiled utility room and with Resident's #2 and #57. This is evidenced by trash and food observations on the floor inside the resident's pantry room on the East side nursing station, Resident #2 tube touching floor, staff not wearing proper personal protective equipment (PPE) when entering droplet precaution rooms during meal tray distribution and Improper hygiene during care. There were 96 residents residing at the facility at the time of the survey.

The findings included:

1) On at 07:51 AM, Staff were observed not wearing PPE while entering a contact/droplet resident room while distributing breakfast trays.

2) On at 11:02 AM, observation of Care. The Care Nurse gathered supplies that consist of kerlix, normal

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, tape, 4 x 4 gauze, scissors, red bag and chuck pads. The Care Nurse locked the computer and cart, knocked on the residents' door, provided privacy, washed , applied gown and double gloves. The old dated . The Care Nurse removed the old and one pair of gloves. The Care Nurse sanitized the gloves and applied a new pair of gloves. The Care Nurse cleaned the , removed one pair of gloves and applied another pair of gloves. The Care Nurse placed power and 4 x 4 gauze on the , wrapped the kerlix and dated the tape on the . The Care Nurse removed the gloves, gown, washed , throwed the red bag in biohazardous bin in the biohazard room, washed and signed off on treatment record.

Review of the medical records for Resident #57 revealed the resident was admitted to the facility on . Clinical diagnoses included but were not limited to: Unspecified open , right lower , initial encounter.

Review of the Physician's Orders Sheet on revealed that Resident #57 had an order for - External Sheet (-) Apply to Left lateral , every day shift every other day for Surgical Cleanse left lateral with normal , , dry, apply Ag sheet cover with 4x4 and wrap with kerlix every other day and as needed until resolved and Apply to Left lateral , , as needed for Surgical Cleanse left lateral with normal , , dry, apply Ag sheet cover with 4x4 and wrap with kerlix every other day and as needed until resolved.

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Review of the Physician's Orders Sheet on revealed that Resident #57 had an order to Offload heels with pillows while in bed as tolerated, every shift.

Review of the Physician's Orders Sheet on revealed that Resident #57 had an order for a air mattress in place to promote healing and as preventative measures. Check for proper functioning every shift.

Review of the Physician's Orders Sheet on revealed that Resident #57 had an order to Turn and reposition every (q) 2 hours (hrs) and as needed, every shift.

Record review of Resident #57's Minimum Data Set (MDS) dated revealed: Section C for Patterns documented a ( ) Score of 15, on a 0-15 scale indicating the resident is . Section GG for Functional Abilities documented the resident is dependent on toileting, showering, upper and lower body . Section H for and documented Resident #57 is always . Section J for Health Conditions documented no since admission. Section K for Nutrition documented no or unknown loss or gain of 5% or more in the last month or loss or gain of 10% or more in the last 6 months. Section M for Skin Conditions documented and pressure injury device for bed.

Record review of Resident #57's Care Plans revealed the resident has a of the right lateral lower and is at risk for

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F 880	Continued From page 47 complication. Interventions include- air mattress in place to promote healing and as preventative measures. Check for proper functioning every shift. Monitor Levels. Monitor pressure areas for color, sensation, temperature. Interview on at 11:23 AM with the Care Nurse it was stated she has been the care nurse at this facility since 2022. The measurements for the on were 6.2x4.7x0.2 cm and it is improving but the resident is non-compliant and refuses treatment or medications. The Resident has that slow down healing process. She has supplements like for hair, skin and nails. The Resident is on enhanced barrier precautions for the open . The Resident has , management and receives and around the clock. The Resident has orders for an air mattress for , pillow , turn and reposition every 2 hours, bunny and weekly skin checks by nurses. The protocol for the new resident would be doing a skin integrity assessment form. She would fill out the form with the residents' information, do a -to- assessment, document and if they have a , she would asses the and call whichever doctor is responsible. I would ask the doctor what to order for the patient, insert the orders and make a note. There is a log for residents with on admission and initial treatment. The Care Nurse states she would put an order for an air mattress if required and call the family to explain what was found. The podiatrist comes every Thursday. The podiatrist sees patients with from the down	F 880		

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and the doctor see patients , and up. The doctor comes on Tuesday's. The Care Nurse states she rounds with the doctors. The surveyor asked the Care Nurse why she used doubled gloves during the care and she stated it is within the protocol and she has doubled gloved during care observations in the past with the Agency for Healthcare Administration (AHCA) and they have been okay with it.

3) Interview on at 12:54 PM with Staff H, Registered Nurse (RN) stated before entering the room, I fully apply PPE before going inside. Gown, gloves and mask. I received education about control and handwashing by Staff T, RN. The staff test for covid almost every day and a staff nurse does it. The residents stay .

Interview on at 12:30 PM with Staff I, Licensed Practical Nurse (LPN) stated, I have been a nurse at the facility for 12 years. Before entering a residents room, the staff should put on PPE which consist of gloves, gown and mask. As a nurse, I would only test residents if they have signs or symptoms of covid. After the resident is positive, they should have 3 negative tests to be taken off isolation. I have received education about handwashing and control by a supervisor or Staff T, RN.

Interview on at 02:20 PM with Staff J, LPN it was stated before entering a residents room that is covid positive, I would put on my PPE. I received education on handwashing and control almost everyday by Staff T, RN. The supervisors test the residents to see if they are still are positive and they stay in isolation.

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F 880	Continued From page 49 Interview on at 01:58 PM with DON it was stated I have been the DON at the facility for 2 months. Staff should perform hygiene when they encounter residents rooms, handling soiled linen or handling and passing out trays. Staff receive education monthly, have surveillance and on spot teaching by Staff T, RN. Staff should not double glove when giving care to residents. Staff should throw away gloves and wash . Interview on at 01:09 PM with Staff E, Certified Nursing Assistant (CNA) stated I have been a CNA at the facility for one year. If a resident is covid positive I would put on mask, gown and gloves before entering the room. I have received education on control and washing, last year by Staff T, RN. I would wash my before feeding resident's, giving care, after taking out garbage, laundry and before passing food trays. Interview on at 01:15 PM with Staff F, CNA stated I have been a CNA at the facility for 24 years. If a resident is covid positive I would wear a gown, glove, hat and mask before entering the room. I have received education on control and washing, yesterday by Staff T, RN. Interview on at 01:24 PM with Staff G, CNA stated she has been a CNA at facility for 40 years. If the resident was covid positive, I would clean my , knock, apply gown, gloves, mask and shield for droplet precautions. My last education on control and handwashing was given a month ago by Staff T, RN.	F 880		

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Review of the facility policy and procedure regarding washing/ hygiene states all personnel shall be trained and regularly in-serviced on the importance of hygiene in preventing the transmission of healthcare-associated . All personnel shall follow the handwashing/ hygiene procedures to help prevent the spread of to other personnel, residents, and visitors. hygiene products and supplies (sinks, soap, towels, -based rub, etc.) shall be readily accessible and convenient for staff use to encourage compliance with hygiene policies. The use of gloves does not replace washing/ hygiene. Integration of glove use along with routine hygiene is recognized as the best practice for preventing healthcare-associated . Single-use disposable gloves should be used: Before , procedures; When , contact with or , ; When in contact with a resident, or the equipment or environment of a resident, who is on contact precautions.

4) On at 7:01 AM an observation was made of trash and food on the floor inside the East side nursing station resident's pantry room (see photo). The Surveyor notified Staff L, Licensed Practical Nurse (LPN) and Staff L stated, "The Resident's pantry room is used to store residents' food and residents who are capable are allowed to get ice and use the microwave. The surveyor asked why there was trash and food on floor and Staff L, LPN replied, "I don't know, I cleaned it when I came on shift. Housekeeping cleans the room in the morning." On at 8:43 AM the Environmental Services Director was interviewed about how and

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when the pantries are cleaned and stated, "I clean the residents' pantry Monday thru Friday. Another Housekeeping staff cleans the resident pantry on weekends at 5:00am. There are two resident pantries. That staff member called to let me know she would be late and at that time it was the Porter's responsibility to clean the Pantry.
On at 8:54 AM Staff Q, Housekeeping staff stated, "I normally come in at 5:30 am and clean the pantry. Today I came in at 8:00am and I cleaned it at 8:00am."
On at 9:08 AM Staff R, Environmental Services (porter) was interviewed and stated, "I started work at 5:30am. When I come in I take out the trash Soiled Utility room and then checked the pantry and all the shower rooms. I did not clean the Resident pantry yet when you saw it because I was still taking out the trash from around the building."

5) On at 7:10 AM The East side Soiled utility room was toured with Staff L, LPN. Staff L, LPN observed entering the room by inputting a code on a keypad. No concerns were observed inside the Soiled Utility room.
When the surveyor walked away, Staff L, LPN was overheard telling another staff member that the door doesn't lock.
At that time, the Surveyor returned to Soiled Utility room with Staff R, Environmental Services (porter) and Staff L, LPN and both staff revealed the Soiled Utility Room door was not able to locked.
On at 7:58 AM the Maintenance Director revealed the lock was fixed and noted in the maintenance logbook.

6) On at 7:56 AM a mask and

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supplement carton was observed in the East Side shower room photo obtained).

7) On at 10:20 AM There was an observation of two room doors with Droplet Precaution signs posted ajar. The signs included instructions that the door is to be closed at all times (photo obtained). The surveyor observed Staff O, Certified Nursing Assistant (CNA) in the hallway. The surveyor asked if it is within their protocol to leave doors open when residents are under Droplet precautions and Staff O, CNA replied, "Sometimes the residents ask to leave the door open. I do not know why the doors were left open, but I will close them." Staff O, CNA closed both doors.

8) On at 7:38 AM Resident#2 was observed in bed with in progress at 2 Liters per minute via a , no apparent distress was noted. The tubing was observed touching the floor (photo obtained).

07:42 AM Staff N, Licensed Practical Nurse (LPN) stated, "I did a double and when I rounded this morning, and I checked on Resident#2. At that time the tubing was not touching the floor. It appears the reason it was touching the floor was because someone lowered the bed too low. I round every two hours and as needed to make sure the proper interventions are in place. I communicate with the Certified Nursing Assistant (CNA) about required interventions for care and I will reinforce."

at 7:53 AM Staff P, CNA stated, "I am the CNA taking care of Resident#2 today. I have

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received in-services care and the nurse speaks to me about care. I empty the collection bag and record the amount. I don't allow the collection bag to touch the floor. I also make sure it is anchored to the bed. I made rounds this morning and the tubing was not touching the ground and I did not lower the bed. The bed should not be too low because the tubing or bag might touch the ground for control purposes.

On at 8:10 AM the Nursing educator advised the surveyor that the system was changed.

On at 10:24 AM the Director of Nursing (DON) was interviewed about control concerns and stated, "I have given several in-services about Enhanced Barrier Precaution (EBP) multiple times. The sign says when to use the Personal Protective Equipment (PPE).

On at 11:44 AM the DON revealed the nursing educator does frequent rounds on the floors and observes staff performing hygiene care and does on the spot teachings. We have 14 residents under Droplet Precautions for either Covid or exposure to Covid. Staff are required to don a gown, mask, gloves, a shield is optional. The residents on Droplet Precaution doors should be closed. Some residents don't like having the door closed and request to leave it open. It is not recommended to leave the door open but we try to honor residents' rights and if that can't be done we find alternative means and it is care planned. We in-serviced all staff about Covid outbreak, hygiene, donning PPE, early signs and symptoms of Covid on . Staff are to monitor residents' to make

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F 880	Continued From page 54	F 880		

sure the is draining properly and tubing is not kinked, or touching the floor. The Soiled Utility room door should be kept locked to prevent any .

Record review of a POLICY/PROCEDURE: SUBJECT: Prevention and Control and Surveillance Program DATE: , 2020 INTENT: It is the policy of the facility to ensure that the Control Program is designed to prevent, identify, report, investigate, and control the spread of and communicable for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement; provide a safe, sanitary and comfortable environment; and to help prevent the development and transmission of and , in accordance with State and Federal Regulations, and national guidelines. PROCEDURE: 1. The facility will establish and maintain an prevention and control program under which it: a. Prevents, identifies, reports investigate, and controls the spread of and communicable in the facility;

An additional record review revealed a Policy titled SUBJECT: Standard and Transmission-based Precautions. DATE: (no date) INTENT: It is the policy of the facility to ensure that appropriate prevention and control measures are taken to prevent the spread of communicable and in accordance with State and Federal Regulations, and national guidelines. PROCEDURE: Transmission-based Precautions 1. Transmission-based precautions include airborne, contact, and droplet precautions. Residents requiring airborne precautions will be

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F 880	Continued From page 55 transferred to a hospital or other health care facility with airborne precaution capability. Residents that require contact and or droplet precautions may remain at this facility. a. Staff are to put on a mask upon room entry and removed upon room exit of resident placed on droplet precautions. 12. a. Staff are to put on gowns and gloves upon room entry and remove gowns and gloves upon exit of resident room. Further record review revealed a policy titled Enhanced Barrier precautions revealed date written: POLICY: Enhanced Barrier Precautions (EBP) will be in place for residents as set forth by CMS guidance pertaining to Multidrug-Resistant Organisms (MDRO's) in Memorandum Ref: QSO-24-08-NH , . Residents will be evaluated on admission for the need for EBP.	F 880		

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F 000	INITIAL COMMENTS An unannounced off-hour recertification survey was conducted , to , at Miami Shores Nursing and Rehab Center. The facility was not in compliance with 42 CFR 483, Requirements for Long Term Care Facilities. The follwing is a description of the non-compliance:	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	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 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 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, interviews and record reviews, the facility failed to provide privacy for residents' information on two out of four computer screens on the East side nursing station as evidenced by an observation of an unlocked, unattended computer screen with resident information easily accessible/visible on the east side medication cart #1 and at the East side nursing station. There were 96 residents residing in the facility at the time of the survey. The findings included: 1.On at 7:39 AM, an observation was made of an unlocked, unattended computer screen on the East side medication cart #1 (photo obtained). On at 7:41 AM Staff H, Registered Nurse (RN) returned to the medication cart and was asked by the surveyor the protocol for keeping residents' information private on computer screens and replied, "I am supposed to lock the screen before I walk away. I was worried about getting the supervisor for you, so I forgot to lock the screen." 2. On at 8:08, an observation was made of an unlocked, unattended computer screen at the East side nursing station with resident information visible (photo obtained). On	F 583	This Plan of Correction does not constitute admission or agreement by Miami Shores Nursing & Rehabilitation Center of the truth of the facts alleged, or conclusions set forth in the statement of deficiencies. This Plan of Correction is prepared solely because it is required by State and Federal Laws. F583 Personal Rights and Confidentiality Identify patients that were at risk and what did: Immediately, once identified by the surveyor, all Department managers were notified and asked to meet with their staff and go over HIPPA and protection of patient privacy. A facility wide Inservice was held on	

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F 583	Continued From page 2 at 8:09 AM Staff M, Licensed Practical Nurse (LPN) was notified by the surveyor about the observation and immediately locked the computer and locked the screen and stated another staff member left it open." Record review of an undated Policy revealed SUBJECT: Patient Privacy DIVISION: Administration DOS Risk Management Services Director DATE: Patient Privacy Policy for Nursing Homes Purpose: The purpose of this policy is to ensure the protection of patient privacy and confidentiality in accordance with applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA) and state-specific regulations. The policy to safeguard personal, medical, and financial information of residents in the nursing home, promoting trust, dignity, and respect. Scope: This policy applies to all employees, contractors, volunteers, and other personnel working in the nursing home, including those who handle patient records, communicate with patients, and interact with their families. Definitions: 1.Patient Information: All personally identifiable information (PII) and protected health information (PHI) about residents, including medical, financial, and personal details. 1. Confidentiality: The duty to protect patient information from unauthorized disclosure, access, or use. 2. Protected Health Information (PHI): Any information related to a patient's health condition, treatment, or payment that can be used to identify the patient. 4. Electronic Health Records (EHR): ⌣ version of a patient's medical history, including their treatment plans, medications, and . . . Policy Statement 1. Confidentiality and Privacy: a. All patient information must be treated as confidential. Unauthorized access, use, or	F 583	through /2025that reviewed HIPPA privacy and all staff were started on individual HIPPA training. The assessment completed included the issue, Root Cause Analysis and Performance improvement Plan. Staff Were trained on specific Education related to HIPPA with acknowledgement forms. Regarding the Nurse that left the computer unattended at med cart was counseled on the importance of HIPPA and protecting privacy, counseling was completed on . How will you identify other patents that are at risk? A full house audit was completed on . , to determine that no other Privacy screens were being left unattended by not only nurses but staff that use the tablets for documentation as well. Staff and Managers were remind of HIPPA Policy and Department managers were tasked to keep vigilant about any screens with patient information being left unattended. Thereafter the DON created the Audit checklist to spot check for computer security during use.	

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F 583	Continued From page 3 disclosure of patient information is prohibited. b. Patient information, whether written, electronic, or verbal, should only be disclosed to individuals who have a legitimate need to know, in compliance with legal and regulatory requirements.2. Access to Patient Information: a. Only authorized personnel who require patient information to perform their duties may access PHI. b. Patient information should be stored securely, and access to records must be restricted to those with proper authorization. 4. Electronic and Paper Records: a. Electronic records must be stored in password-protected systems with encryption to prevent unauthorized access. b. Paper records containing PHI should be securely stored in locked areas, and any physical documents that are disposed of should be shredded.	F 583	Measure put in place: A facility wide Inservice was held on and /2025that reviewed HIPPA privacy and all staff were started on individual HIPPA training. The assessment completed included the issue, Root Cause Analysis and Performance improvement Plan. Staff Were trained on specific Education related to HIPPA with acknowledgement forms. Training will continue upon Hire and annual review. A new system tool has been created whereby the Nurse manager that covers 24 hrs per day has a form that was developed and included the surveillance of HIPPA Compliance with all electronics including computers and tablets. The DON create an audit checklist which will be located at Nurses desk and is a daily spot checks for computer security during use. All department heads are also required to monitor for the same on their daily rounds and when finding any non-compliant staff, to report to managers and provide ongoing education and progressive discipline if rules are not adhered to.	

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F 583	Continued From page 4	F 583	We posted a sign at nurses' station and on med carts as a reminder to Lock screens before leaving long term prevention through inclusion and annual training and Orientation. How will you monitor? The DON and All department Heads are also required will use the form to track compliance. The DON and or designee will be responsible for bringing the finding and summary to the QAPI Committee. This will occur daily for 30 days, then Monthly for 3 months, then quarterly and or if any variances are reported ongoing.	
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:	F 645		

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(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 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

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F 645	Continued From page 6 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 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 observations, record review and interview, the facility failed to ensure the Preadmission Screening and Resident Review (PASARR) Level I was completed accurately prior to admission for three Residents (#50, #83, #60) out of three residents reviewed for PASARR. There were 96 residents residing in the facility at the time of the survey. The findings Included: Record review of the Pre-Admission Screening and Resident Review (PASARR) Policy and Procedure dated 2016 documented: Policy Intent-It is the policy of the facility to assure that all residents admitted to the facility receive a Pre-Admission Screening and Resident Review;	F 645	F-645 PASARR screening for MD and ID Identify patients that were at risk and what did: Patients #50, 83 & 60 were reassessed in the PASSAR. Resident #50 was discharged on , home with Daughter. Patients #83 and #60 remain in the facility. PASARS were reevaluated to reflect proper diagnosis, and PASARR resident review screening was requested. This was completed on for resident #83. Ref #60 the resident review was completed on .	

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F 645	Continued From page 7 Procedure-1) A facility will coordinate assessments with the pre-admission screening and resident review (PASARR) program as stated under Federal Regulations. 1) Observation of Resident #50 on at 11:07 AM revealed the resident sitting up in bed with the television on. Record review of the Demographic Sheet for Resident #50 documented the resident was admitted on with diagnoses of , , , , , and . The resident was readmitted to the facility on . Review of the PASARR for Resident #50 revealed the PASARR Level I was done on with no diagnoses of and , checked on the form with documented history. The form documented no PASARR Level II was required. PASARR Level I was completed by a Social Worker at the hospital on . Review of the Minimum Data Set (MDS) 5 Day Assessment for Resident #50 dated documented the resident's Mental Status ( ) Summary Score had a Summary Score of 00 out of 15 indicating severe , , resident is currently not considered by the state level II PASRR process to have a SMI (Severe Mental Illness) or ID (Intellectual ,) or a related condition and the resident required substantial/maximal to dependent assistance for ADLs (Activities Daily Living). On at 7:30 AM, interview with the Admissions Director. She stated, "We update the	F 645	A full house audit was completed , identified the issues, all residents PASSARs were reviewed for accuracy. How will you identify other patents that are at risk: On a QAPI Meeting occurred to review the PASSAR and provided education to the committee. A full house audit was completed , identified the issues, all residents PASSARs were reviewed for accuracy. The consistency of the audit was to make the PASSAR□s Level 1 and 2 are accurate and in place. Any updates were made and being made during the course of the audit. Measures put in Place: The facility admissions team will work with local hospitals to ensure prior to admission, that the screening uses the PASSAR criteria. Admissions Director and Director of Nursing as well Social Service were provided the PASSAR education on .	

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F 645	Continued From page 8 PASARR, when they come here, if it is incorrect." On at 8:07 AM, interview and record review with the Director of Nursing (DON). She stated, "The PASSR was incorrect and should have included the diagnoses for and ." 2) Observation of Resident #83 on at 11:12 AM revealed the resident sitting up in bed, asleep with a machine off and with the television on. Record review of the Demographic Sheet for Resident #83 documented the resident was admitted on with diagnoses of acute failure, , affective and . Review of the PASARR for Resident #83 revealed the PASARR Level I was done on with no diagnoses of , , , , and Affective checked on the form documented history and medications. The form documented no PASSAR Level II was required. PASARR Level I was completed by a Registered Nurse Worker at the hospital on . Review of the Minimum Data Set (MDS) Significant Change Assessment for Resident #83 dated documented the resident's Mental Status ( ) Summary Score had a Summary Score of 00 out of 15 indicating severe , , resident is currently not considered by the state level II PASARR process to have a SMI or ID or a related condition and the resident required partial/moderate to dependent assistance for ADLs (Activities Daily Living).	F 645	The Director of Nursing and admissions will review all new admissions during the week, to ensure accuracy during morning meeting and on weekend a nursing supervisor will review for accuracy and compliance, and if patient was readmitted to compare with prior PASSAR to ensure if any new changes have occurred. Additionally, the Social Service Department and Nursing will also address when Physician changes orders for , , medications, then the PASSAR will be reviewed and updated if necessary. The MDS Department will also be part of reevaluating during the quarterly assessments. Additionally, as of a QAPI tool was developed as part of Pre-Admission Screening & Resident Review (PASSAR) Audit was implemented and will be done upon admission and Gang Tackling , which is the facilities continuous quality improvement program Monthly Review. How will you monitor:	

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F 645	Continued From page 9 Review of the Physician's Order Sheet (POS) for and for Resident #83 documented the resident received Oral Tablet 25 MG (milligrams) Give 1 tablet via at bedtime for and Oral Tablet 10 MG Give 1 tablet via in the morning for . Review of the Care Plans for Resident #83, written documented the resident received medications. On at 7:54 AM, interview with the Social Services Assistant. She stated, "The Admissions Office checks the PASARRs." On at 8:08 AM, interview and record review with Director of Nursing (DON). She stated, "The PASARR was incorrect and should have included the diagnoses for , and Affective ." 3) On at 10:57 AM while sitting in the dining area, the surveyor overheard yelling in the hallway. The surveyor observed Resdient #60 standing in the doorway yelling. Multiple staff members were observed speaking to Resident#60 in a calm manner however Resident #60 continued to yell. Minutes later, Resident #60 agreed to sit in a chair in the doorway of the room. Record review of a demographic sheet for Resdient #60 revealed an admission date of and a readmission date of with diagnoses that included: , , with due to Known	F 645	The Administrator/ Nursing Management team and or Designee will review all admissions for compliance and keep a running list for QAPI. Pre-Admission Screening & Resident Review (PASSAR) Audit will be done upon admission and Gang Tackling Monthly Review. The Admissions Director and Director of Nursing and or designee will be responsible for bringing the findings and summary to the QAPI Committee. This will occur Monthly for 3 months, then quarterly and or if any variances are reported ongoing.	

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F 645	Continued From page 10 condition, Record review of an Annual Minimum Data Set reference dated revealed A1500. Preadmission Screening and Resident Review (PASRR), Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual , or a related condition? - No. Section I revealed (other than), Section N- and Section O- E. , E1. Total minutes - record the total number of minutes this was administered to the resident in the last 7 days- 0. Record review of Care Plan initiated on and revised on revealed Resident #60 was noted with physically aggressive behaviors, had a goal to demonstrate effective coping skills through the review date. (Target Date:) and interventions included: When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later and / consult as indicated. Record review of a physician's order sheet revealed orders dated to monitor for side effects r/t (related to) , med use and to Oral Tablet 50 milligrams directions: Give 1 tablet by at bedtime related to . Record review of a PASARR Level 1 dated revealed Section I: PASARR Screen Decision-Making A. or suspected (check all that	F 645		

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apply): no diagnosis was checked.

The surveyor requested the most recent PASARR from the Director of Nursing (DON). The Nursing Home Administrator presented the surveyor with a PASARR for Resident #60, dated
Section I: PASARR Screen Decision- Making A.
or suspected (check all that apply): no diagnosis was checked.

Interview with the Nursing Supervisor stated, "Resident #60 was seen by yesterday and I will complete a new PASARR." The Nursing Supervisor presented a PASRR for Resident#60, dated to Surveyor which revealed:
Section I: PASRR Screen Decision- Making A.
or suspected (check all that apply):
was checked.

On the DON presented the Surveyor with a Progress note written by the Psychiatrist dated . The progress note revealed a diagnosis that included:

On , the Director of Admission and the Director of Nursing were interviewed about the PASRR process. The Director of Admissions stated, "Upon admission I work with the Social workers in the hospitals prior to admission, to gather the clinicals and a completed PASARR. Sometimes the PASARRs are incomplete, and the diagnoses don't reflect the current medications the residents are taking. In this instance, I refer to the DON. The PASARR is used to make sure the resident is in the right setting due to any or mental illness. If the resident is transferred to the hospital and returns in less than 30 days it is not required to update the PASARR. When Resident #60 was

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admitted there was no medication for ,
and that is why no diagnoses were checked.

On the DON stated, "When residents are admitted I review the medications and the history to make sure it is correctly reflected on the PASARR. We review the PASARRs monthly and/or when there is a change in behavior. PASARRs are also discussed in the morning meeting and the social worker is made aware and any new changes are care planned. We also get a , or psychologist consult for the resident. The PASARR for Resident #60 should have been updated at the time the , was prescribed to reflect all current mental illness diagnoses. The Psychiatrist evaluated Resident #60 yesterday ( ) due to Resident #60 exhibiting increased , and prescribed a new medication. Resident #60 is typically quiet, requires redirection and that is effective.

Record review of a Policy and Procedure titled, Subject: Pre-Admission Screening and Resident Review (PASARR) Program" revealed:
DATE: 2016
INTENT:
It is the policy of the facility to assure that all residents admitted to the facility receive a Pre-Admission Screening and Resident Review, in accordance with State and Federal Regulations.
DEFINITIONS:
For purposes of this Policy:
1. An individual is considered to have a mental if the individual has a serious mental defined in 483.102(b) (1).
2. An individual is considered to have an intellectual , if the individual has an intellectual , as defined in §483.102(b) (3)

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or is a person with a related condition as described in 435.1010 of this chapter.
§483.20(k)(4) A nursing facility must notify the state mental health authority or state intellectual , authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual , for resident review.
PROCEDURE:
1. A facility will coordinate assessments with the pre-admission screening and resident review (PASARR) program as stated under Federal Regulations to the maximum extent practicable to avoid duplicative testing and effort. Coordination
1. Incorporating the recommendations from the PASARR level II
determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.
2. Referring all level II residents and all residents with newly evident or possible serious mental , intellectual , or a related condition for level II resident review upon a significant change in status
2. The facility will not admit, on or after , , any new residents with:

A. Mental , 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:
i. That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
ii. If the individual requires such level of services, whether the
individual requires specialized services; or

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B. Intellectual , as unless the State intellectual or authority has determined prior to admission:
i. That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
ii. If the individual requires such level of services, whether the individual requires specialized services for intellectual .
3. Exceptions. For purposes of this requirement include:
1. The preadmission screening program under paragraph(k)(1) of the regulation 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.
2. The State may choose not to apply the preadmission screening program under paragraph (k)(1) of the regulation to the admission to a nursing facility of an individual:
Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
Who requires nursing facility services for the condition for which the individual received care in the hospital, and
iii.
Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.
4. Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If the facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.

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F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and , , needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and , , well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. ( )In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care	F 656		

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F 656	Continued From page 16 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and -informed. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to develop and implement comprehensive care plans for Residents #43, #74 and #291 as evidenced by no comprehensive care plan with interventions for floor mats for one resident (#291), no implementation of a care plan for one resident (#74) out of 6 residents who use floor mats and no care plan for a brace for one (#43) out of two residents who require braces. There were 96 residents residing in the facility at the time of the survey. The findings included: 1. On at 7:54 AM Resident#291 was observed in bed with one floor mat on the resident's right side, a call light was in reach. Another observation on 08:53 AM revealed floor mats were in place for Resident #291. Record review of a demographic sheet for Resident #291 revealed an admission date of with diagnoses that included: , , and Collapse, Wasting and Atrophy. Record review of an admission Minimum data set (MDS) reference dated revealed Resident	F 656	F-656 Develop Implement Comprehensive Care Plan Identify patients that were at risk and what did: Ref Resident #43 Regarding Resident #43 the brace with appropriate interventions was added to Care Plan. How will you identify other residents that are at risk: 100 % audit was completed to identify residents with brace. Any residents with brace were reviewed to ensure appropriate Care Plan was completed. Measures put in place: Upon admissions residents are assessed for devices. Any Devices such as braces or other devices are reviewed upon admission and reviewed in our	

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F 656	Continued From page 17 #291 had a Brief Interview of Mental Status ( ) score of 9, indicated moderate , and required supervision or touching assistance for rolling left and right and partial/ for Sit to stand, transfer and walking 10 . Record review of a Care Plan initiated on and revised on revealed Resident #291 was at risk for and had no interventions pertaining to floor mats. Record review of Resident #291's current physician order sheet revealed no current orders for floor mats. On at 11:45 AM, Staff H, Registered Nurse (RN) was interviewed about how many floor mats are required for Resdient #291 and stated, "I was the nurse on Sunday and there was only one floor mat present on the Resident #291's left side because the resident usually gets out on that side of the bed." On at 1:58 PM The MDS Coordinator stated, "The floor mats had not been care planned until today for Resident #291." 2. On at 9:53 AM Resident#74 was observed in bed, no distress, appears , bed low, call light in reach, one floor mat on the right side of resident. Staff N, LPN was asked how many floor mats are to be present and replied, "I will check and get to you." Record review of a demographic sheet for Resident#74 revealed an admission date of with diagnoses that included: wasting and Atrophy right upper arm, Right and	F	morning meeting. During morning meeting the MDS Coordinator will update and validate to the team when this is completed. Restorative Nursing will be maintaining a weekly checklist of all new devices and will be addressed on care plan. Also training was completed on for care plan team members regarding Floor mats, C- Collar Devices and Following Physician Orders. Nursing staff to communicate and document anytime a resident refuses treatment such as the C-Collar to update care plan . This will be reported and presented to the QAPI committee to ensure compliance. All nursing staff were in-serviced on assistive devices (brace and floor mats). How will you monitor: The Director of Nursing, MDS Coordinators, Restorative Nurse and or Designee will be responsible for bringing the findings and summary to the QAPI Committee. This will occur Monthly for 3 months, then quarterly and or if any variances are reported ongoing Ref Resident #74 Regarding Resident #74 the Care Plan was completed with appropriate interventions to address	

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F 656	Continued From page 18 Left Lower , and Difficulty in walking. Record review of a Quarterly Minimum data set (MDS) reference dated revealed Resident#74 had a Brief Interview of Mental Status ( ) of score 00, indicated severe , , uses walker and wheelchair, required partial/ for walking and transfer. Record review of a care plan initiated on and revised on revealed Resident#74 was at risk for and had interventions that included: Provide floor mats for precautions and safety. Record review of a physician order sheet for Resident#74 revealed no orders for floor mats. Interview on at 11:02 AM Staff N, Licensed Practical Nurse (LPN) stated, "I am the nurse assigned to R#74 today. This resident is under precautions. One intervention is the floor mat on the right side of the resident because this is the side he usually tries to get up from the bed. I have observed this resident sitting on the right side of the bed. He can walk short distances with assistance and uses a wheelchair. The floor mat is used for safety precautions. This resident is to have one floor mat." On at 1:34 PM the MDS Coordinator nurse presented the surveyor with a revised care plan for at risk of with a revised intervention dated : Provide right floor mats for precautions and safety. On at 1:58 PM the MDS Coordinator stated, "I am in charge of completing and	F 656	How will you identify other residents that are at risk: 100 % audit was completed to identify residents at risk for and Care Plan with appropriate interventions. Measures put in place: Upon admissions residents are assessed for risk. Any residents at risk for a Care Plan will be completed with appropriate interventions to address . This will be reported and presented to the QAPI committee to ensure compliance. All nursing staff were in-serviced on precautions and floor mats. How will you monitor: Through the continuous quality improvement program (Gang tackling) we will monitor compliance. The Director of Nursing, MDS Coordinators, Restorative Nurse and our Designee will be responsible for bringing the findings and summary to the QAPI Committee. This will occur Monthly for 3 months, then quarterly and or if any variances are reported ongoing.	

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F 656	Continued From page 19 updating care plans in conjunction with the nursing staff. The Restorative nurse communicates with me for residents who require floor mats for precaution. R#74's care plan was revised today ( ) to reflect an intervention from floor mats to one floor mat on the right side. This intervention started over the weekend." On at 8:24 AM the Restorative/ care nurse stated, "Upon admission if a resident has a history of we put them in a program that includes close monitoring for 30 days, a low bed, and floor mat. The amount of floor mats are determined by the side the resident is observed trying to get out the bed without assistance. Sometimes it can be both sides. Resident #74 and #291 are not able to walk independently. We don't need a physician's order to implement floor mats. The floor mats are care planned. The floor mats were implemented for Resident #291 on the weekend due to observations by staff of Resident #291 trying to get out of bed. I told staff to place one floor mat on the side of the window. I informed MDS on Tuesday, . On at 11:44am the Director of Nursing (DON) was interviewed by the surveyor about care planning concerns for floor mats. The DON stated there is a 24 hour report in the electronic health record where staff can check the updated status of residents. No order is required for floor mats but should be care planned. There is also a binder kept at the nursing stations that contain residents' who require floor mats. The Restorative nurse updates that binder. Record review of a Policy titled Comprehensive	F 656	Ref Resident #291 Regarding Resident #291 the Care Plan was completed with appropriate interventions to address floor mats. How will you identify other residents that are at risk: 100 % audit was completed to identify residents with floor mats and Care Plan in place with appropriate interventions. Measures put in place: Upon admissions residents are assessed for floor mats. Any residents found to need a floor mat a Care Plan will be completed with appropriate interventions to address . This will be reported and presented to the QAPI committee to ensure compliance. All nursing staff were in-serviced on floor mats. (risk for) How will you monitor: Through the continuous quality improvement program (Gang tackling) we will monitor compliance. The Director of Nursing, MDS Coordinators, Restorative Nurse and our Designee will be responsible for bringing the findings and summary to the QAPI Committee. This will occur Monthly for 3 months, then quarterly and or if any variances are	

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F 656	Continued From page 20 Care Plans DATE: 2010 REVISED: revealed DEPARTMENT: Nursing INTENT: It is the policy of the facility to promote seamless interdisciplinary care for our residents by utilizing the interdisciplinary plan of care based on assessment, planning, treatment, service and intervention. It is utilized to plan for and manage resident care as evidenced by documentation from admission through discharge for each resident. Every resident will have an Interdisciplinary Care Plan, with the Interim Interdisciplinary Care Plan initiated within 24 hours of admission. The care plan will identify priority problems and needs to be addressed by the interdisciplinary team, and will reflect the resident's strengths, limitations and goals. The care plan will be complete, current, realistic, time specific and appropriate to the individual needs for each resident. There will be ongoing documentation of the nursing process related to resident needs from admission to discharge. The interdisciplinary plan of care will be developed through collaborative efforts of the Interdisciplinary Team and other health care professionals. It will be consistent with the medical plan of care and those disciplines that have direct involvement with the resident's care. The resident and/or family member will be involved in the care planning. The care plan will contain information about the physical, emotional/, , , , spiritual, educational and environmental needs as appropriate. Developing the Care Plan: 1. The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing,	F 656	reported ongoing.	

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F 656	Continued From page 21 and mental and , , needs that are identified in the comprehensive assessment. 2. The comprehensive care plan will describe the following: b. Any services that would otherwise be required per regulation but are not provided due to the resident's exercise of rights, including the right to refuse treatment. Updating Care Plans: 1. Care plans are modified between care plan conference when appropriate to meet the resident's current needs, problems and goals. 3. The Care Plan will be updated and/or revised for the following reasons: d. A change in planned interventions; 3) In an observation conducted on at 06:51 AM revealed, resident #43 lying in bed and stated that she was feeling tired. There were no visible signs of distress or discomfort at the time of observation. Her environment appeared to be calm, and no immediate concerns were noted. Observation of resident # 43 on at 09:11 AM. The resident was observed lying in bed the of the bed was raised, and the resident stated she was tired. Observation of resident # 43 on at 01:14 PM. The resident was lying in bed, speaking very disoriented. Record review revealed Resident # 43 was originally admitted to the facility on . Resident #43 diagnoses included 's without dyskinesia, without mention of fluctuations. Review of the physician's orders dated 11:00pm Revision: revealed the	F 656		

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resident must Keep C-collar in place at all times. Remove during care and inspect skin call MD if any abnormalities every shift.

Record review of Resident # 43 Admission Minimum Data Set (MDS) Section C Pattern in the ( ) documented 00 out of 15. Section G for functional status indicated the resident needs Supervisor/Touching Assistance for activities of daily living (ADL). The facility did not have a care plan for the use of the C-collar.

Interview with Staff K, Registered Nurse (RN) on at 9:14 AM revealed upon record review that the C-collar was to always kept in place, at this moment she proceeded to have the surveyor speak to restorative services for further information.

Interview with the Assistant (PTA) on at 09:38AM revealed the resident is not doing at this time, she revealed the resident is in a restorative program doing exercise and the surveyor needed to speak with someone from restorative.

Interview with Staff G, Restorative Certified Nursing Assistant (CNA) on at 10:05 AM revealed the resident was supposed to wear the C-collar constantly, but that normally she doesn't like to sleep in it, or wear it in the dining room, she also mentioned they continue to educate her of the importance of her wearing the C-collar. When the surveyor asked where the C-collar is now, the restorative aide revealed it is in the laundry, she stated the sponge is wet at the moment, but they will finish drying it and would place it on the resident.

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F 656	Continued From page 23 Interview with DON on at 02:14 PM revealed about the frequency of staff monitoring resident # 43, the DON responded that every 2 hours, the DON also mentioned the resident had been participating in a prevention program. Furthermore, she stated that in Resident # 43 had a CT (Computed) scan for further evaluation, and the results were sent to the for reevaluation of the removal of the C-collar and no new order were received. Record review of the facility's policy and procedure to follow physicians order. Effective date 2005/Revised 2021 under Policy: The purpose is to ensure that residents receive care and services in timely a manner when orders are given by their Physicians. Policy 1. Physician orders will be followed as prescribed. If not followed, reason will be documented in Residents medical records.	F 656		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, the facility failed to provide supervision to prevent safety hazards for one resident (#2) out	F 689	F-689 Free of Hazards / Supervision /Devices	

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F 689	Continued From page 24 of 32 sampled residents as evidenced by an observation of an electrical cord plugged into an outlet suspended in the air in such a way that caused a tripping hazard in the room of Resident#2. There were 96 residents residing in the facility at the time of the survey. The findings included: On at 9:44 AM an observation was made of an electrical cord for the air mattress wrapped around the side table, extending and suspended in the air, which caused a tripping hazard in the room of Resident #2. Staff H, Registered Nurse (RN) was present in the room at the time of the observation and was notified by the surveyor of the potential tripping hazard. Staff H, RN readjusted the plug behind the bed. On at 12:18 PM the Nursing Home Administrator (NHA) was made aware by the surveyor about the tripping hazard observation and stated, "Electrical should be behind the bed and plugged into the wall unit to avoid a tripping hazard." On at 3:00 PM the NHA informed the surveyor that all plugs are now zip tied to the bed frame to prevent any tripping hazard. The NHA showed the surveyor a picture that revealed the electrical cord was zip tied around the bed frame. Record review of a demographic sheet for Resident #2 revealed an admission date of and a readmission date of with diagnoses that included: Acute Failure with and Covid-19. Record review of a significant change in status	F 689	Identify patients that were at risk and what did: Patient #2 bed cord was identified by surveyor and told Administrator; the director of plant operations was instructed tie all the to the frame to be removed from any potential trip hazard. Thereafter, A full house audit was completed after surveyors identified the issues on potential tripping hazards. All rooms were checked for safety on How will you identify other patents that are at risk: A full house audit was completed after surveyors identified the issues on potential tripping hazards. All rooms were checked for safety. Staff were also Inservice on to discuss the risk of tripping hazards Measures put in Place: On and Staff were inserviced on all risk and precautions and safety measures that required. Upon admission, resident rooms are assessed for room safety. The supervisor that is on site will provide a new QAPI	

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F 689	Continued From page 25 Minimum data set (MDS) reference dated revealed Resident#2 had a Brief Interview of Mental Status ( ) score of 12, indicating moderate , no potential indicators of , was dependent on staff for Chair/bed-to-chair transfer and no since Admission/Entry or Reentry or Prior Assessment. Record review of a Care Plan initiated on and revised on revealed Resident#2 was at risk for related to Monoplegia of right dominant side, and had interventions that included: Follow facility protocol. Record review of physician order sheet revealed an order dated for Low air loss mattress in place as preventative measures and to promote healing. Check for proper functioning every shift. Record review of the policy (undated) titled, "Miami Shores Nursing and Rehabilitation Safety and Supervision of Residents: revealed a Policy Statement: Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Policy Interpretation and Implementation. Facility-Oriented Approach to Safety 4. Employees shall be trained and in serviced on potential accident hazards and how to identify and report accident hazards, and try to prevent avoidable accidents. Resident Risks and Environmental Hazards 1. Due to their and scope, certain resident risk factors and environmental hazards are addressed in dedicated policies and procedures. These risk factors and environmental hazards include:	F 689	Comprehensive Supervisor Rounding tool form that spot checks rooms with any potential trip hazards such a and any electronic charging devices. We have also added to our Gang Tackling Quality programs where scheduled rooms are checked monthly to ensure that any findings out normal are addressed immediately and reported to Management. The Forms are part of Housekeeping and Maintenance department QAPI Tracking. . Training occureed on staff were also provided with 6-point training on overall safety hazzrds and the risk associated. The supervisor form will be handed to DON for compliance tracking. How will you monitor: The DON /Maintenace and Housekeeping Supervisors will be responsible for bringing the findings and summary to the QAPI Committee. This will occur Monthly for 3 months, then quarterly and or if any variances are reported ongoing.	

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F 689	Continued From page 26 Electrical Safety.	F 689		
F 690 SS=D	CFR(s): 483.25(e)(1)-(3) §483.25(e) §483.25(e)(1) The facility must ensure that resident who is of and on admission receives services and assistance to maintain unless his or her clinical condition is or becomes such that is not possible to maintain. §483.25(e)(2)For a resident with , based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an is not unless the resident's clinical condition demonstrates that was necessary; (ii) A resident who enters the facility with an or subsequently receives one is assessed for removal of the as soon as possible unless the resident's clinical condition demonstrates that is necessary; and (iii) A resident who is of receives appropriate treatment and services to prevent and to restore to the extent possible. §483.25(e)(3) For a resident with fecal , based on the resident's comprehensive assessment, the facility must ensure that a resident who is of receives appropriate treatment and services to restore as much normal function as possible.	F 690		

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F 690	Continued From page 27 This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, the facility failed to provide appropriate treatment and services for care for one (Resident #2) out of one resident who has a as evidenced by observations of the tubing being kinked, and touching the floor. There were 96 residents residing in the facility at the time of the survey. The findings included: On at 9:35 AM Resident #2 was observed in bed with in progress at 2Liters per minute via a and no apparent distress was noted. A tubing was observed kinking in a circle and the was not properly draining (photo obtained). Staff H, Registered Nurse (RN) was present in the room and was notified by the surveyor about the kinking of the tubing. Staff H, RN then straightened out the tubing to allow free flow of . Staff H, RN was asked by the surveyor the correct way to position the tubing and Staff H stated, "I round every morning and check the tubing. This morning, I found the night nurse was working with the , so I didn't notice it was kinked." On at 7:38 AM Resident #2 was observed in bed with in progress at 2 Liters per minute via a , no apparent distress was noted. The tubing was observed touching the floor (photo obtained). On 07:42 AM Staff N, Licensed Practical	F 690	F-690 / Care Identify patients that were at risk and what did: Regarding Resident #2 the drainage tubing was immediately changed, bed was raised. Assigned Nurse and C.N.A were immediately in-service on control protocol and the difference between Super pubic and regular . Identify patients that were at risk and what did: 100% audit was completed to identify residents with care and/or to ensure bags are not kinked and not touching the floor. All nurses and CNAs were educated on though on control protocol and the difference between Super pubic and regular . Measures put in Place: A clinical Inservice was held for all nursing staff on through to discuss care and control protocol.	

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F 690	Continued From page 28 Nurse (LPN) stated, "I did a double and when I rounded this morning, and I checked on Resident #2. At that time the tubing was not touching the floor. It appears the reason it was touching the floor was because someone lowered the bed too low. I round every two hours and as needed to make sure the proper interventions are in place. I communicate with the Certified Nursing Assistant (CNA) about required interventions for care and I will reinforce." On at 7:53 AM Staff P, CNA stated, "I am the CNA taking care of Resident #2 today. I have received in-services on care and the nurse speaks to me about care. I empty the collection bag and record the amount. I don't allow the collection bag to touch the floor. I also make sure it is anchored to the bed. I made rounds this morning and the tubing was not touching the ground and I did not lower the bed. The bed should not be too low because the tubing or bag might touch the ground for control purposes. On at 8:10 AM the Nursing educator advised the surveyor that the system was changed. Record review of a demographic sheet for Resident#2 revealed an admission date of and a readmission date of with a diagnosis that included Neuropathic . Record review of a significant change in status Minimum data set (MDS) reference dated revealed Resident#2 had a Brief Interview of Mental Status ( ) score of 12, indicated	F 690	How will you monitor: The supervisor that is on site will provide a new QAPI Comprehensive Supervisor Rounding tool form that spot checks rooms with Safety as far as positioning and ensuring that it is not touching the floor. Additionally, the supervisor form will be handed to DON for compliance tracking. The DON created A care random audit observations checklist. The random audit will be done daily. Continuous in-service on the care of residents with super pubic and will be done monthly and as needed	

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F 690	Continued From page 29 moderate , was dependent on staff for personal hygiene care, had , and . Record review of a Care Plan initiated on and revised on revealed Resident #2 had a related to and is at risk for complication with goals that included: be free of any s/s of through review date and interventions that included: Check tubing for kinks each shifts, Check bag for any leakage and change as needed. Record review of the physician order sheet revealed an order dated for - care every shift and as needed, Change bag weekly every night shift every Sunday Change (16)FR every night shift every 1 month(s) starting on the last day of month for 1 day(s). On 01:58 PM Staff N, LPN was asked if this resident#2 has a ? and Staff N replied, "No." On at 2:15 PM Staff S, Nursing supervisor approached the surveyor and revealed Resdient #2 had a . On at 8:48 AM Staff N, LPN was reinterviewed and stated, "Resident #2 has a . I thought it was an ( ) because that is what this resident had before he went out to the hospital. I didn't know it was changed to a . I usually only empty the collection bag. After I spoke to you, I completed a skin check and realized there was a , ,	F 690		

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F 690	Continued From page 30 in place." On at 11:44 AM the Director of Nursing (DON) was made aware of the concerns and asked about procedures and protocols when providing care and stated, "Staff are to monitor the to make sure the is draining properly, tubing is not kinked or touching the floor. Also stated, "The physician orders pertaining to care for Resident #2 should have included instead of and they were updated on ." Record review of a Policy titled, " Care written: revision date: revealed: POLICY/PROCEDURE: The purpose of this procedure is to prevent of the resident's tract. STEPS: 10. Secure and check drainage tubing and bag to ensure that the is draining properly.	F 690		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized	F 761		

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F 761	Continued From page 31 personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Prevention and Control Act of 1976 and other drugs subject to , except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to properly store medications as evidenced by an observation of a box of expired Rapid (Covid-19) test kits in one medication storage room and an unlocked cart (cart #1) on the west wing unit, and an unattended medication at the bedside for resident #2. The Findings included: 1) Accompanied by Staff S, an observation of the West Wing medication storage room was conducted on at 09:50 AM. The observation revealed a box with multiple expired Covid-19 test kits inside the bottom cabinet. Each Covid-19 test kit was observed with an expiration date of . Staff S, Registered Nurse (RN) supervisor confirmed the expiration date and removed a box of multiple expired Covid-19 test kits. On at 02:58 PM, Staff S stated: "The nursing supervisors are the ones in charge of monitoring and checking the medication storage room each shift. The supervisor from each shift is	F 761	F-761 Label Drug and Biologicals Identify patients that were at risk and what did: Once identified by surveyor the staff address of expired COVID Test, they were discarded. Central supply and Nursing managers educated immediately when identified by the surveyor and the Pharmacy consultant held a meeting with all nurses' about this topic on about expired medications and provided education. The nurse that left the medication cart unlocked was disciplined on . An Inservice with all nurses was done on to ensure compliance with Storage Biologicals Medications, Med Pass Administration and procedure by Pharmacist consultant. The DOH did a pharmacy audit on .	

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F 761	Continued From page 32 responsible of checking the crash cart, med room, and the pantry. When we find something or medication expired, we package it and return to pharmacy. If there is a medication that is expired in the med cart, we remove it right away and place it in the return bin for the DON (Director of Nurses) to waste it with the pharmacy. We are also supposed to place a sign on the box when it is expired, stating it cannot be used. To my understanding, a nurse cannot use a covid test without checking the expiration date first. We usually always have in-services regarding how long we are supposed to use, for example, the lancets, , , , solution for Accu-Check, covid tests, over the counter meds and where to look for the expiration date. Prior to administering medication, we are always supposed to check the expiration. We also have to label the Accu-Chek solution with the date it was opened and the date of expiration." On at 03:10 PM the Director of Nursing (DON) stated: The nursing supervisor and DON checks the medication storage rooms daily. If there are any supplies that are expired, we discard immediately. The expired covid test that you found, can still be used because there is an extended expiration date. It is stated in the FDA (Food and Drug Administration) website. The OHC (.... Healthcare) self-tests were the ones that were expired." 2) On at 7:21 AM the surveyor was walking in the hallway, and an observation was made of the an unlocked medication cart (cart #1) on the West side nursing station. Staff U, Registered Nurse (RN) approached the medication cart and was asked by the surveyor about the protocol for medication storage. Staff	F 761	How will you identify other patents that are at risk: Medication Rooms and Medication Carts were checked for expired medications once identified by surveyor. DON and Nurse management checked med carts. The pharmacy was contacted to help with Med pass Inservice and came to educate nurses on . The Inservice included ensuring keeping carts locked when not in use and expired meds. Measures put in Place: The supervisor that is on site will provide a new QAPI Comprehensive Supervisor Rounding tool form that spot checks rooms with Medication Administration sample. The supervisor form will be handed to DON for compliance tracking. In-service completed by Pharmacy consultant on for all nurses on expired medications and provided education. Training was also done by the Consultant pharmacist on regarding any expired testing kits and or medications.	

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F 761	Continued From page 33 U, RN replied, "The medication cart should be locked when I walk away from it, but I forgot because I was moving quickly to assist residents." 3) On at 9:35 AM the Surveyor entered the room of Resident #2. Staff H, RN was observed attempting to flush a for Resient#2 to administer medication. Staff H was unable to flush the tube and told the surveyor that she would leave the room to retrieve an item to assist with the procedure. Staff H, RN exited the room. There was a cup of crushed medication mixed in water on the side table and a with a lancet on the side of the sink (photo obtained). On at 10:33 AM Staff H, RN returned and was asked by the surveyor about the protocol for leaving medications. Staff H replied, "I left the medication and with the lancet in the room because you (surveyor) were present. The proper protocol is to take the medications and materials with me." On 11:44 AM the DON and Nursing Home Administrator were informed of the observation and stated, "The nurse didn't know she could not leave medications unattended." Record review of a Policy and Procedure titled, "Medication Storage" dated 2001 MED-PASS, Inc. (Revised ,) revealed a Policy Statement: The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. Policy Interpretation and Implementation: 2. The nursing staff shall be responsible for maintaining medication storage AND preparation areas in a clean, safe, and sanitary manner. 4. The facility shall not use discontinued, outdated, or	F 761	The inservice also included ensuring keeping carts locked when not in use. The DON Created new audit tolls called on -Medication Cart Audit -Treatment Cart Audit -Med room Audit Investigator , from the Florida Department of Health Division of Medical Quality Assurance conducted an inspection . No findings. How will you monitor: The Pharmacist will conduct a monthly audit of all medications and Carts. Nursing staff will conduct weekly audit of all medication and carts. The DON Managers and Consultant Pharmacist will be responsible for bringing the findings and summary to the QAPI Committee. This will occur Monthly for 3 months, then quarterly and or if any variances are reported ongoing.	

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F 761	Continued From page 34 deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed. 7. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others. 8. Drugs shall be stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Each resident's medications shall be assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medications of several residents.	F 761		
F 814 SS=D	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the facility failed to assure cardboard boxes were properly disposed and contained on the facility grounds. Cardboard boxes were scattered on the ground outside the kitchen door. The findings included: Record review of the Food-Related Garbage and Rubbish Disposal Policy and Procedure revised documented: Policy Statement-Food-related garbage and rubbish shall be disposed of in accordance with current state laws regulating such matters; Policy Interpretation and Implementation-4) Food	F 814	F-814 Dispose Garbage and Refuse property: Identify patients that were at risk and what did: Once identified by surveyor with multiple cardboard boxes on the ground and not contained in the garbage bin. The Certified Dietary manager and Registered Dietician met with staff on and to ensure that the empty cardboard boxes were no longer allowed to be left unattended and not broken down and discarded. No residents were placed	

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MIAMI SHORES NURSING AND REHAB CENTER	9380 NW 7TH AVENUE MIAMI, FL 33150

(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
F 814	Continued From page 35 storage boxes/containers will be disposed of by the end of each shift into the outside dumpsters. Observation of the outside of the facility at the kitchen door with the Dietary Aide A on at 7:01 AM. There were multiple cardboard boxes on the ground and not contained in the garbage bin. Photographic evidence submitted. On at 7:03 AM, interview with Staff A, Dietary Aide. She stated, "Someone is supposed to break down the cardboard boxes and take them to the garbage container. They should not be on the ground." On at 8:27 AM, interview with the Dietary Director. He revealed that the carboard boxes were removed from the ground outside of the kitchen door and should not have been on the ground.	F 814	at risk. How will you identify other patents that are at risk: Once identified by surveyor with multiple cardboard boxes on the ground and not contained in the garbage bin. The Certified Dietary manager and Registered Dietician met with staff on and to ensure that the empty cardborad boxes were no longer allowed to be left unattended and not broken down and discarded. No residents were placed at risk. Measures put in Place: The CDM / RD or designee created a QAPI spot check form and created a new process to Discard cardboard boxes by dietary staff. This Inservice was completed on and . Additionally, a Cardboard only bin was placed on the outside of building as a general cardboard disposal location. All other non-dietary boxes were also detailed to be broken down and discarded in a main garbage container. How will you monitor: The CDM /RD or designee will be responsible for bringing the findings or	

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F 814	Continued From page 36	F 814	progress to the QAPI Committee. This will occur Monthly for 3 months, then quarterly and or if any variances are reported ongoing.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and ( ) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; ( ) For public health activities, reporting of ,	F 842		

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neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(h)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(h)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
( ) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review and interviews, the facility failed to ensure residents' medical records are accurate in accordance with accepted professional standards and practices for one (Resident #33) out of one resident

F-842 Resident Records- identifiable Information

Identify patients that were at risk and what

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F 842	Continued From page 38 sampled, as evidenced by a Nurses' Progress Note for Resident#33 documented the resident was COVID 19 positive and the resident was COVID 19 negative. These practices has the potential to affect any of the residents residing in the facility. The findings included: Record review of the Charting and Documentation Policy and Procedure revised documented: Policy Statement-All services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record; Policy Interpretation and Implementation-1) All observations, medications administered, services performed must be documented in the resident's clinical record; 2) Entries may only be recorded in the resident's clinical record by licensed personnel (Registered Nurse, Licensed Practical Nurse, Physician, ,). Review of the Charting Errors and/or Omissions Policy and Procedure revised documented: Policy Statement-Accurate medical records shall be maintained by this facility; Policy Interpretation and Implementation-1) If an error is made while recording the data in the medical record, Staff member will be added to the medical record as an error. Review of the Demographic Sheet for Resident #33 documented the resident was admitted on with diagnoses that included but not limited to , , , , , , , , protein-calorie and atherosclerotic .	F 842	did: Once identified by surveyor regarding Resident #33 , the Director of Nursing contacted the LPN that erroneously documented that the patient was COVID positive when he was not and was asked to clarify the note. This was done on . How will you identify other patents that are at risk: The LPN received a 1:1 training on Accurate Documentation on . An audit was done on all remaining residents with diagnosis to ensure that the documentation was correct. Measures put in Place: An Inservice was done for all Nurses on Resident Records- Identifiable Information and Resident Accuracy was started for all nurses on , and ongoing. Example of Error identified was presented and discussed. Thereafter, DON has an ongoing QAPI Plan for incorrect documentation Audit Tool. This was started on as a weekly review.	

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F 842	Continued From page 39 Review of the Minimum Data Set (MDS) Quarterly Assessment dated for Resident #33 documented the resident's Brief Interview of Mental Status ( ) Summary Score was 00, indicating severe , and required dependent assistance for ADLs (activities daily living). Review of the Nurses' Progress Notes for Resident #33 dated at 06:48 documented: Resident remaining in droplet/contact precaution for COVID 19 positive results using z pack in this moment , , with positive improvement. Review of the Physician's Order Sheets (POS) and Medication Administration Records (MAR) for documented the resident was not receiving or a Z pack (, ,). On at 8:04 AM during an interview and record review, with the Director of Nursing (DON) it was stated, "He does not have COVID. He does not receive any such as Z pack. The progress note is inaccurate." On at 9:59 AM during an interview with Staff B, Licensed Practical Nurse (LPN) revealed that the resident is not COVID positive.	F 842	How will you monitor: The DON or designee will be responsible for bringing the findings and summary to the QAPI Committee. This will occur Monthly for 3 months, then quarterly and or if any variances are reported ongoing.	
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	F 867		

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F 867	Continued From page 40	F 867		

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 [redacted] 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, 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,

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F 867	Continued From page 41 and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies and procedures: (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 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	F 867		

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F 867	Continued From page 42 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 interview and record review, the facility failed to demonstrate effective plans of actions were implemented to correctly identify quality deficiencies in the problem area related to repeated deficient practices for F880 Prevention & Control, as evidenced by the control protocol was not followed on the east side soiled utility room and failed to follow control protocol for one Resident # 57, as evidenced by a failure to implement hygiene. There were 96 residents residing in the facility at the time of the survey.	F 867	F-867 QAPI/QAA Improvement Activities Identify patients that were at risk and what did: Initially the management team created a QAPI from the initial exit with areas of concerns. We started immediate in-services since and changed systems and	

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F 867	Continued From page 43 The findings included: Record review of the facility's survey history revealed, during a recertification survey with exit dated , F880 Prevention & Control was cited related to the fact that the facility failed to implement control procedures for three (Residents 89, 347, 348) out of 28 sampled residents. Interview with the Director of Nursing (DON) on at 03:44 PM. She stated that the Quality Assurance and Performance Improvement (QAPI) meetings are held each month. She stated that QAPI committee members are Medical Director, Administrator, Director of Nursing, Social Services, Business Office Manager, Dietary, MDS (Minimum Data Set), and Care. She stated that they have daily meetings, and monthly recap meetings. They started reviewing the last meeting and focusing on the deficiencies the facility had in the last survey. She stated the way they monitor Quality Assurance is to continuously communicate with the different departments and make sure we track the corrective actions implemented. They also provide in-service education and regular performance review. She said staff addresses any concerns to their supervisor. Residents with ⌄ issue get ⌄ weekly, if residents are not eating they have a team put a plan into place. When asked about staffing, she revealed they met the state requirements and they have increased supervision 7:00am-7:00pm. Record review of Quality Assurance/Quality Assurance Performance Improvement QAPI/QAA	F 867	strengthened our quality Assurance process and created all new tracking tools. Once the final 2567 came though we updated the audits and worked on our plans as a team. Ref F880 QAPI action Plan: Once identified by surveyor, all staff that distribute meal service were reeducated on and on on the process of Donning and Duffing when entering a room with droplet precautions. Once identified by the surveyor, resident #57 was assessed and is in stable condition. Regarding staff member that double gloved, she was counselled on for the not following proper control procedures. Once identified by the surveyor, all staff were reeducated on the process on hygiene and also were provided individual education with acknowledgement. All staff were in serviced on keeping the Common and the Pantry areas cleaned with no trash to be found on the floor and this was done on Once identified by the surveyor the batteries were replaced by the Director of	

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F 867	Continued From page 44 Goals/Purpose Statement: Our purpose is to provide excellent quality resident/patient care and services. Quality is defined as meeting or exceeding the needs, expectations and requirements of the patients cost-effectively while maintaining good resident/patient outcomes and perceptions of patient care. [...] has a Performance Improvement Program which systematically monitors, analyses and improves its performance to improve resident/ patient outcomes. It recognizes that the value in healthcare is the appropriate balance between good measures, excellent care and services and cost. We will monitor our operations for compliance with federal and state regulations.	F 867	Plant Operations and is now monitoring randomly to ensure that the battery-operated lock system is working regularly. All shower rooms are the responsibility of any staff member that enters the shower room to take a resident into the shower room, there will be no Cartons or food related permit nor masks in the shower room. Resident Tubing touching the floor education was done on When a patient is on Droplet precaution, we will do all possible to keep doors closed at all times. If the resident cannot comply due to mental state or is at risk the team will care plan and possibly look for alternatives to include discharge. We will always try to mediate the issue for compliance with standards. We also have to honor the fact that this is their home and will work on reasonable accommodation's How will you identify other patents that are at risk: Ref F880 QAPI action Plan Besides the care nurse all staff were re-educated on Control procedures on /25,	

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F 867	Continued From page 45	F 867	Also, the Administrator and DON along with QAPI committee met to review the policies again and to ensure staff education is reinforced with additional in-services. New tools were created to help with tracking and trending and ensuring that not only this citation is followed on the monthly QAPI Review but have a purposeful tracking and trending system with education and return demonstrations when applicable. Measures put in Place: Besides the care nurse all staff were re-educated on Control procedures on /25, Also, the Administrator and DON along with QAPI committee met to review the policies again and to ensure staff education is reinforced with additional in-services. New tools were created to help with tracking and trending and ensuring that not only this citation is followed on the monthly QAPI Review but have a purposeful tracking and trending system with education and return demonstrations when applicable. The following identified areas were used for education to staff and will be	

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maintained on our QAPI for the remainder oif the year for tracking and trending data:

F583-(N202) Personal Rights and Confidentiality

F-645 PASSAR Screening

F-656- (N054 and N072) Develop and Implement Care Plans

F-761- (N095) - label Drugs and Biologicals

F-842- Resident Records Indetifiable Information

F-814 Dispose Garbage and Refuse Property

F-867- QAPI/ QAA Improvement Activitues

F-880- control

- Control Plan

-Proper techniques of Donning and Doffing

-Droplet vs Enhance Barrier Precaution

-Meal tray distribution

-Transmission Based Precautions

- Hygiene

- High Touch areas

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F 867	Continued From page 47	F 867	-Linen Handling Including clean and Soiled Cath Tubing not touching the floor Nursing focus will include - , Cath Care - , , cath Care - - care Enviromental Enviromental Common area and Pantry Care Soiled utility locks to ensure that they are functional K 353 Tags Sprinkler System K355- Tags- Sprinkler Regulations Maintence and Tesing K 741 Smoking regulations K-918 Essential Electrical Systems K923 Cylinder and Container Storage	

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F 867	Continued From page 48	F 867	How will you monitor: The Administrator and Director of Nursing will be responsible for bringing the findings and summary to the QAPI Committee. This will occur Monthly for 3 months, then quarterly and or if any variances are reported ongoing. Since QAPI was identified as needing improvement we have changed the reporting and all citations will have a structured monitoring designated by accountable reporting, trending, analysis and follow through.	
F 880 SS=E	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: §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	F 880		

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F 880	Continued From page 49	F 880		

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

§483.80(e) Linens.
Personnel must handle, store, process, and

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F 880	Continued From page 50 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 interviews, the facility failed to follow their control protocol in the East side soiled utility room and with Resident's #2 and #57. This is evidenced by trash and food observations on the floor inside the resident's pantry room on the East side nursing station, Resident #2 tube touching floor, staff not wearing proper personal protective equipment (PPE) when entering droplet precaution rooms during meal tray distribution and Improper hygiene during care. There were 96 residents residing at the facility at the time of the survey. The findings included: 1) On at 07:51 AM, Staff were observed not wearing PPE while entering a contact/droplet resident room while distributing breakfast trays. 2) On at 11:02 AM, observation of Care. The Care Nurse gathered supplies that consist of kerlix, normal , tape, 4 x 4 gauze, scissors, red bag and chuck pads. The Care Nurse locked the computer and cart, knocked on the residents' door, provided privacy, washed , applied gown and double gloves. The old dated . The Care Nurse removed the old and one pair of gloves. The Care Nurse sanitized the gloves and applied a	F 880	Ref F880 QAPI action Plan: Once identified by surveyor, all staff that distribute meal service were reeducated on and on on the process of Donning and Duffing when entering a room with droplet precautions. Once identified by the surveyor, resident #57 was assessed and is in stable condition. Regarding staff member that double gloved, she was counselled on for the not following proper control procedures. Once identified by the surveyor, all staff were reeducated on the process on hygiene and also were provided individual education with acknowledgement. All staff were in serviced on keeping the Common and the Pantry areas cleaned with no trash to be found on the floor and this was done on Once identified by the surveyor the batteries were replaced by the Director of Plant Operations and is now monitoring randomly to ensure that the battery-operated lock system is working	

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F 880	Continued From page 51 new pair of gloves. The Care Nurse cleaned the , removed one pair of gloves and applied another pair of gloves. The Care Nurse placed power and 4 x 4 gauze on the , wrapped the kerlix and dated the tape on the . The Care Nurse removed the gloves, gown, washed , threw the red bag in biohazardous bin in the biohazard room, washed and signed off on treatment record. Review of the medical records for Resident #57 revealed the resident was admitted to the facility on . Clinical diagnoses included but were not limited to: Unspecified open , right lower , initial encounter. Review of the Physician's Orders Sheet on revealed that Resident #57 had an order for - External Sheet (-) Apply to Left lateral , , every day shift every other day for Surgical Cleanse left lateral with normal , , dry, apply Ag sheet cover with 4x4 and wrap with kerlix every other day and as needed until resolved and Apply to Left lateral , , as needed for Surgical Cleanse left lateral with normal , , dry, apply Ag sheet cover with 4x4 and wrap with kerlix every other day and as needed until resolved. Review of the Physician's Orders Sheet on revealed that Resident #57 had an order to Offload heels with pillows while in bed as tolerated, every shift. Review of the Physician's Orders Sheet on revealed that Resident #57 had an	F 880	regularly. All shower rooms are the responsibility of any staff member that enters the shower room to take a resident into the shower room, there will be no Cartons or food related permit nor masks in the shower room. Resident Tubing touching the floor education was done on When a patient is on Droplet precaution, we will do all possible to keep doors closed at all times. If the resident cannot comply due to mental state or is at risk the team will care plan and possibly look for alternatives to include discharge. We will always try to mediate the issue for compliance with standards. We also have to honor the fact that this is their home and will work on reasonable accommodation's How will you identify other patents that are at risk: Initially the management team created a QAPI from the initial exit with areas of concerns. We started immediate in-services since and changed systems and strengthened our quality Assurance process and created all new tracking tools.	

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F 880	Continued From page 52 order for a air mattress in place to promote healing and as preventative measures. Check for proper functioning every shift. Review of the Physician's Orders Sheet on revealed that Resident #57 had an order to Turn and reposition every (q) 2 hours (hrs) and as needed, every shift. Record review of Resident #57's Minimum Data Set (MDS) dated revealed: Section C for Patterns documented a ( ) Score of 15, on a 0-15 scale indicating the resident is . Section GG for Functional Abilities documented the resident is dependent on toileting, showering, upper and lower body . Section H for and documented Resident #57 is always . Section J for Health Conditions documented no since admission. Section K for Nutrition documented no or unknown loss or gain of 5% or more in the last month or loss or gain of 10% or more in the last 6 months. Section M for Skin Conditions documented and pressure injury device for bed. Record review of Resident #57's Care Plans revealed the resident has a of the right lateral lower and is at risk for complication. Interventions include- air mattress in place to promote healing and as preventative measures. Check for proper functioning every shift. Monitor Levels. Monitor pressure areas for color, sensation, temperature.	F 880	Once the final 2567 came though we updated the audits and worked on our plans as a team. The system was revaluated by the QAPI Committee and education was required for all staff since all residents were at risk as a facility wide initiative. The following identified areas were used for education to staff and will be maintained on our QAPI for the remainder oif the year for tracking and trending data: The following identified areas were used for education to staff: F583-(N202) Personal Rights and Confidentiality F-645 PASSAR Screening F-656- (N054 and N072) Develop and Implement Care Plans F-761- (N095) - label Drugs and Biologicals F-842- Resident Records Indetifiable Information F-814 Dispose Garbage and Refuse Property	

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F 880	Continued From page 53 Interview on at 11:23 AM with the Care Nurse it was stated she has been the care nurse at this facility since 2022. The measurements for the on were 6.2x4.7x0.2 cm and it is improving but the resident is non-compliant and refuses treatment or medications. The Resident has that slow down healing process. She has supplements like for hair, skin and nails. The Resident is on enhanced barrier precautions for the open . The Resident has , management and receives and around the clock. The Resident has orders for an air mattress for , pillow , turn and reposition every 2 hours, bunny and weekly skin checks by nurses. The protocol for the new resident would be doing a skin integrity assessment form. She would fill out the form with the residents' information, do a -to- assessment, document and if they have a , she would asses the and call whichever doctor is responsible. I would ask the doctor what to order for the patient, insert the orders and make a note. There is a log for residents with on admission and initial treatment. The Care Nurse states she would put an order for an air mattress if required and call the family to explain what was found. The podiatrist comes every Thursday. The podiatrist sees patients with from the down and the doctor see patients , and up. The doctor comes on Tuesday's. The Care Nurse states she rounds with the doctors. The surveyor asked the Care Nurse why she used doubled gloves during the care and she stated it is within the protocol and she has doubled gloved during care observations in the past with the Agency for	F 880	F-867- QAPI/ QAA Improvement Activitues F-880- control - Control Plan -Proper techniques of Donning and Doffing -Droplet vs Enhance Barrier Precaution -Meal tray distribution -Transmission Based Precautions - Hygiene - High Touch areas -Linen Handling Including clean and Soiled Cath Tubing not touching the floor Nursing focus will include - Cath Care - cath Care - - care	

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F 880	Continued From page 54 Healthcare Administration (AHCA) and they have been okay with it. 3) Interview on at 12:54 PM with Staff H, Registered Nurse (RN) stated before entering the room, I fully apply PPE before going inside. Gown, gloves and mask. I received education about control and handwashing by Staff T, RN. The staff test for covid almost every day and a staff nurse does it. The residents stay . Interview on at 12:30 PM with Staff I, Licensed Practical Nurse (LPN) stated, I have been a nurse at the facility for 12 years. Before entering a residents room, the staff should put on PPE which consist of gloves, gown and mask. As a nurse, I would only test residents if they have signs or symptoms of covid. After the resident is positive, they should have 3 negative tests to be taken off isolation. I have received education about handwashing and control by a supervisor or Staff T, RN. Interview on at 02:20 PM with Staff J, LPN it was stated before entering a residents room that is covid positive, I would put on my PPE. I received education on handwashing and control almost everyday by Staff T, RN. The supervisors test the residents to see if they are still are positive and they stay in isolation. Interview on at 01:58 PM with DON it was stated I have been the DON at the facility for 2 months. Staff should perform hygiene when they encounter residents rooms, handling soiled linen or handling and passing out trays. Staff receive education monthly, have surveillance and on spot teaching by Staff T, RN.	F 880	Enviromental Enviromental Common area and Pantry Care Soiled utility locks to ensure that they are functional K 353 Tags Sprinkler System K355- Tags- Sprinkler Regulations Maintenace and Testing K 741 Smoking regulations K-918 Essential Electrical Systems K923 Cylinder and Container Storage Measure put in place : The system was revaluated by the QAPI Committee and education was required for all staff since all residents were at risk as a facility wide initiative. System Response Once identified by surveyor, all staff that distribute meal service were reeducated	

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F 880	Continued From page 55 Staff should not double glove when giving care to residents. Staff should throw away gloves and wash . Interview on at 01:09 PM with Staff E, Certified Nursing Assistant (CNA) stated I have been a CNA at the facility for one year. If a resident is covid positive I would put on mask, gown and gloves before entering the room. I have received education on control and washing, last year by Staff T, RN. I would wash my before feeding resident's, giving care, after taking out garbage, laundry and before passing food trays. Interview on at 01:15 PM with Staff F, CNA stated I have been a CNA at the facility for 24 years. If a resident is covid positive I would wear a gown, glove, hat and mask before entering the room. I have received education on control and washing, yesterday by Staff T, RN. Interview on at 01:24 PM with Staff G, CNA stated she has been a CNA at facility for 40 years. If the resident was covid positive, I would clean my , knock, apply gown, gloves, mask and shield for droplet precautions. My last education on control and handwashing was given a month ago by Staff T, RN. Review of the facility policy and procedure regarding washing/ hygiene states all personnel shall be trained and regularly in-serviced on the importance of hygiene in preventing the transmission of healthcare-associated . All personnel shall follow the handwashing/ hygiene procedures to help prevent the spread of	F 880	on and on on the process of Donning and Duffing when entering a room with droplet precautions. Once identified by the surveyor resident #57 was assessed and is in stable condition. Regarding staff member that double gloved, she was counselled on for the not following proper control procedures. Once identified by the surveyor, all staff were reeducated on the process on hygiene and also were provided individual education with acknowledgement. All staff were in serviced on keeping the Common and the Pantry areas cleaned with no trash to be found on the floor, and this was done on Once identified by the surveyor the batteries were replaced by the Director of Plant Operations and is now monitoring randomly to ensure that the battery-operated lock system is working regularly. All shower rooms are the responsibility of any staff member that enters the shower room to take a resident into the shower room, there will be no Cartons or food related permit nor masks in the shower room.	

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F 880	Continued From page 56 to other personnel, residents, and visitors. hygiene products and supplies (sinks, soap, towels, -based rub, etc.) shall be readily accessible and convenient for staff use to encourage compliance with hygiene policies. The use of gloves does not replace washing/ hygiene. Integration of glove use along with routine hygiene is recognized as the best practice for preventing healthcare-associated . Single-use disposable gloves should be used: Before , procedures; When , contact with or , ; When in contact with a resident, or the equipment or environment of a resident, who is on contact precautions. 4) On at 7:01 AM an observation was made of trash and food on the floor inside the East side nursing station resident's pantry room (see photo). The Surveyor notified Staff L, Licensed Practical Nurse (LPN) and Staff L stated, "The Resident's pantry room is used to store residents' food and residents who are capable are allowed to get ice and use the microwave. The surveyor asked why there was trash and food on floor and Staff L, LPN replied, "I don't know, I cleaned it when I came on shift. Housekeeping cleans the room in the morning." On at 8:43 AM the Environmental Services Director was interviewed about how and when the pantries are cleaned and stated, "I clean the residents' pantry Monday thru Friday. Another Housekeeping staff cleans the resident pantry on weekends at 5:00am. There are two resident pantries. That staff member called to let me know she would be late and at that time it was the Porter's responsibility to clean the Pantry. On at 8:54 AM Staff Q, Housekeeping	F 880	When a patient is on Droplet precaution, we will do all possible to keep doors closed at all times, if the resident cannot comply due to mental state or is at risk the team will care plan and possibly look for alternatives to include discharge. We will always try to mediate the issue for compliance with standards. We also have to honor the fact that this is their home and will work on reasonable accommodations Also, the Administrator and DON along with the QAPI committee met to review the policies again and to ensure staff education is reinforced with additional in-services. New tools were created to help with tracking and trending and ensuring that not only this citation is followed on the monthly QAPI Review but have a purposeful tracking and trending system with education and return demonstrations when applicable. The following identified areas were used for education to staff: F583-(N202) Personal Rights and Confidentiality F-645 PASSAR Screening F-656- (N054 and N072) Develop and	

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F 880	Continued From page 57 staff stated, "I normally come in at 5:30 am and clean the pantry. Today I came in at 8:00am and I cleaned it at 8:00am." On at 9:08 AM Staff R, Environmental Services (porter) was interviewed and stated, "I started work at 5:30am. When I come in I take out the trash Soiled Utility room and then checked the pantry and all the shower rooms. I did not clean the Resident pantry yet when you saw it because I was still taking out the trash from around the building." 5) On at 7:10 AM The East side Soiled utility room was toured with Staff L, LPN. Staff L, LPN observed entering the room by inputting a code on a keypad. No concerns were observed inside the Soiled Utility room. When the surveyor walked away, Staff L, LPN was overheard telling another staff member that the door doesn't lock. At that time, the Surveyor returned to Soiled Utility room with Staff R, Environmental Services (porter) and Staff L, LPN and both staff revealed the Soiled Utility Room door was not able to locked. On at 7:58 AM the Maintenance Director revealed the lock was fixed and noted in the maintenance logbook. 6) On at 7:56 AM a mask and supplement carton was observed in the East Side shower room photo obtained). 7) On at 10:20 AM There was an observation of two room doors with Droplet Precaution signs posted ajar. The signs included instructions that the door is to be closed at all times (photo obtained). The surveyor observed	F 880	Implement Care Plans F-761- (N095) - label Drugs and Biologicals F-842- Resident Records Indetifiable Information F-814 Dispose Garbage and Refuse Property F-867- QAPI/ QAA Improvement Activitues F-880- control - Control Plan -Proper techniques of Donning and Doffing -Droplet vs Enhance Barrier Precaution -Meal tray distribution -Transmission Based Precautions - Hygiene - High Touch areas -Linen Handling Including clean and Soiled Cath Tubing not touching the floor Nursing focus will include	

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F 880	Continued From page 58 Staff O, Certified Nursing Assistant (CNA) in the hallway. The surveyor asked if it is within their protocol to leave doors open when residents are under Droplet precautions and Staff O, CNA replied, "Sometimes the residents ask to leave the door open. I do not know why the doors were left open, but I will close them." Staff O, CNA closed both doors. 8) On at 7:38 AM Resident#2 was observed in bed with in progress at 2 Liters per minute via a , no apparent distress was noted. The tubing was observed touching the floor (photo obtained). 07:42 AM Staff N, Licensed Practical Nurse (LPN) stated, "I did a double and when I rounded this morning, and I checked on Resident#2. At that time the tubing was not touching the floor. It appears the reason it was touching the floor was because someone lowered the bed too low. I round every two hours and as needed to make sure the proper interventions are in place. I communicate with the Certified Nursing Assistant (CNA) about required interventions for care and I will reinforce." at 7:53 AM Staff P, CNA stated, "I am the CNA taking care of Resident#2 today. I have received in-services care and the nurse speaks to me about care. I empty the collection bag and record the amount. I don't allow the collection bag to touch the floor. I also make sure it is anchored to the bed. I made rounds this morning and the tubing was not touching the ground and I did not lower the bed. The bed should not be too low because the	F 880	- Cath Care - cath Care - - care Enviromental Enviromental Common area and Pantry Care Soiled utility locks to ensure that they are functional K 353 Tags Sprinkler System K355- Tags- Sprinkler Regulations Maintence and Tesing K 741 Smoking regulations K-918 Essential Electrical Systems K923 Cylinder and Container Storage How will you monitor: The Administrator and Director of Nursing will be responsible for bringing the findings and summary to the QAPI Committee. This will occur Monthly for 3 months, then quarterly and or if any variances are reported ongoing.	

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F 880	Continued From page 59 tubing or bag might touch the ground for control purposes. On at 8:10 AM the Nursing educator advised the surveyor that the system was changed. On at 10:24 AM the Director of Nursing (DON) was interviewed about control concerns and stated, "I have given several in-services about Enhanced Barrier Precaution (EBP) multiple times. The sign says when to use the Personal Protective Equipment (PPE). On at 11:44 AM the DON revealed the nursing educator does frequent rounds on the floors and observes staff performing hygiene care and does on the spot teachings. We have 14 residents under Droplet Precautions for either Covid or exposure to Covid. Staff are required to don a gown, mask, gloves, a shield is optional. The residents on Droplet Precaution doors should be closed. Some residents don't like having the door closed and request to leave it open. It is not recommended to leave the door open but we try to honor residents' rights and if that can't be done we find alternative means and it is care planned. We in-serviced all staff about Covid outbreak, hygiene, donning PPE, early signs and symptoms of Covid on . Staff are to monitor residents' to make sure the is draining properly and tubing is not kinked, or touching the floor. The Soiled Utility room door should be kept locked to prevent any . Record review of a POLICY/PROCEDURE: SUBJECT: Prevention and Control and Surveillance Program DATE: , 2020	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105449	A. BUILDING _____ B. WING _____	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 60	F 880		

INTENT: It is the policy of the facility to ensure that the Control Program is designed to prevent, identify, report, investigate, and control the spread of and communicable for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement; provide a safe, sanitary and comfortable environment; and to help prevent the development and transmission of and , in accordance with State and Federal Regulations, and national guidelines.
PROCEDURE: 1. The facility will establish and maintain an prevention and control program under which it: a. Prevents, identifies, reports investigate, and controls the spread of and communicable in the facility;

An additional record review revealed a Policy titled SUBJECT: Standard and Transmission-based Precautions. DATE: (no date) INTENT: It is the policy of the facility to ensure that appropriate prevention and control measures are taken to prevent the spread of communicable and in accordance with State and Federal Regulations, and national guidelines. PROCEDURE: Transmission-based Precautions 1. Transmission-based precautions include airborne, contact, and droplet precautions. Residents requiring airborne precautions will be transferred to a hospital or other health care facility with airborne precaution capability. Residents that require contact and or droplet precautions may remain at this facility. a. Staff are to put on a mask upon room entry and removed upon room exit of resident placed on droplet precautions. 12. a. Staff are to put on gowns and gloves upon room entry and remove

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F 880	Continued From page 61 gowns and gloves upon exit of resident room. Further record review revealed a policy titled Enhanced Barrier precautions revealed date written: POLICY: Enhanced Barrier Precautions (EBP) will be in place for residents as set forth by CMS guidance pertaining to Multidrug-Resistant Organisms (MDRO's) in Memorandum Ref: QSO-24-08-NH , . Residents will be evaluated on admission for the need for EBP.	F 880		