

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/30/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105765	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/27/2025
NAME OF PROVIDER OR SUPPLIER GARDENS NURSING AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 190 NE 191ST STREET MIAMI, FL 33161		
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F 000	INITIAL COMMENTS An unannounced survey for Complaint numbers 2025003445 and 2025003849 were conducted to _____ at Gardens Nursing & Rehabilitation Center. The complaint allegation were substantiated. The facility was not in compliance with 42 CFR 483. Requirements for Long Term Care Facilities. The following is a description of the non-compliance.	F 000			
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	F 656			

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 656	<p>Continued From page 1</p> <p>findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>() In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(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.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(iii) Be culturally-competent and -informed. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, record review and interviews, the facility failed to develop and implement a discharge care plan for one (Resident # 1) out of three resident whose discharge care plans were reviewed. There were 106 residents residing in the facility at the time of this survey.</p> <p>The findings included:</p> <p>Record review of Resident # 1's clinical records revealed the resident was admitted to the facility on _____ and discharged on _____</p> <p>Clinical diagnoses include Displaced Tri malleolar of Right Lower , Subsequent Encounter for Closed with Routine Healing, Encounter for Other Orthopedic</p>	F 656			

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F 656	<p>Continued From page 2 Aftercare.</p> <p>Record review of orders dated _____ indicated the resident was to be discharged home with family on _____.</p> <p>Review of the Admission Minimum Date Set (MDS) Section C for _____ Patterns dated _____ revealed the Brief Interview of Mental Status (_____) summary score was 07 out of 15 indicating severe _____. The section for Functional Abilities dated _____ revealed the resident was independent for eating, oral hygiene, toileting hygiene, upper body _____ and personal hygiene. The resident needed partial/ _____ for shower/bath and lower body _____ and needed substantial/maximal assistance for putting on/taking off footwear.</p> <p>Record review of the overall Discharge Summary revealed the resident is to be discharged home with family. No medical equipment needed, or home health requested. The resident choice to be discharged on _____.</p> <p>Review of the Admission Baseline Care Plan dated _____ indicated on the Initial Admission/Discharge: Remain in the facility.</p> <p>Review of the MDS Discharge Return Non- _____ Information dated _____ revealed the resident was discharged to home/community.</p> <p>Review of the Nursing Home Transfer and Discharge Notice dated _____ /2025 revealed the facility gave the resident a 30-day notice to vacate the facility due to the resident's unpaid bill</p>	F 656			

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F 656	<p>Continued From page 3</p> <p>for services received at the facility after reasonable and appropriate notice to pay</p> <p>Based on observations, record review and interviews, the facility failed to develop and implement a discharge care plan for one (Resident # 1) out of three resident whose discharge care plans were reviewed. There were 106 residents residing in the facility at the time of this survey.</p> <p>The findings included:</p> <p>Record review of Resident # 1's clinical records revealed the resident was admitted to the facility on _____ and discharged on _____ Clinical diagnoses include Displaced Tri malleolar of Right Lower _____ Subsequent Encounter for Closed _____ with Routine Healing, Encounter for Other Orthopedic Aftercare.</p> <p>Record review of orders dated _____ indicated the resident was to be discharged home with family on _____</p> <p>Review of the Admission Minimum Date Set (MDS) Section C for _____ Patterns dated _____ revealed the Brief Interview of Mental Status (_____) summary score was 07 out of 15 indicating severe _____ The section for Functional Abilities dated _____ revealed the resident was independent for eating, oral hygiene, toileting hygiene, upper body _____ and personal hygiene. The resident needed partial/ _____ for shower/bath and lower body _____ and needed substantial/maximal assistance for putting on/taking off footwear.</p>	F 656			

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F 656	<p>Continued From page 4</p> <p>Record review of the overall Discharge Summary revealed the resident is to be discharged home with family. No medical equipment needed, or home health requested. The resident choice to be discharged on .</p> <p>Review of the Admission Baseline Care Plan dated indicated on the Initial Admission/Discharge: Remain in the facility.</p> <p>Review of the MDS Discharge Return Non- Information dated revealed the resident was discharged to home/community.</p> <p>Review of the Nursing Home Transfer and Discharge Notice dated /20205 revealed the facility gave the resident a 30-day notice to vacate the facility due to the resident's unpaid bill for services received at the facility after being given reasonable and appropriate notice to pay.</p> <p>Interview on at 1:35 PM the Social Services Director revealed she is not in charge of the development of care plans, and she is in charge of the Nursing Home Transfer and Discharge Notice.</p> <p>Interview on at 1:50 PM; the MDS Coordinator revealed she is in charge of the development of care plans. The MDS Coordinator acknowledge the resident did not have any discharge care plan.</p> <p>Record review of the facility's Policies and Procedures for Care Plan-Comprehensive with effective date revealed Overview: An individualized comprehensive care plan that</p>	F 656			

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F 656	Continued From page 5 includes measurable objectives and timetable to meet the resident's medical, nursing, mental and needs is developed for each resident. Policy: Our facility's care plan planning/interdisciplinary team, in coordination with the resident, his/her family or representative (sponsor, develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. Procedure: 5- The resident's comprehensive care plan is developed within seven (7) days of the completion of the resident's comprehensive assessment.	F 656		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure are secure for two (Residents #7, and Resident #8) out of two residents reviewed for . As evidenced by Resident #7's was observed in the hallway carry his bag in his and at times placing it on the floor. Resident # 8 was observed with the 's drainage bag on his , and the tubing on the wheelchair's wheels. These	F 684		

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F 684	<p>Continued From page 6</p> <p>deficient practices increases the risk for related urological if the is unintentionally pulled resulting in dislodgement.</p> <p>The findings include:</p> <p>Resident #7</p> <p>On at 10:05 AM, Resident#7 was observed in the hallway with his resting on his . At the time of the observation, there was no privacy bag in use to cover the . (Photographic evidence)</p> <p>On at 11:28 AM, Resident#7's was observed on the floor, the was not properly secured or positioned. A staff member was noted performing 15-minute checks on residents, and did not notice the bag on the floor (Photographic evidence)</p> <p>On at 03:00 PM, Staff X, Licensed Practical Nurse (LPN), entered Resident #7's room. The nurse picked up the bag and placed it on the side of the bed while the resident was sitting in the wheelchair; if the resident were to roll the wheelchair, there was a potential risk of the being dislodged.</p> <p>Review of the medical records for Resident #7 revealed the resident was initially admitted to the facility on . Clinical diagnoses include but not limited to of the unspecified obstruction, prostatic hyperplasia without lower tract symptoms and</p>	F 684			

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F 684	<p>Continued From page 7</p> <p>Review of Resident#7's Physician's Orders for included but not limited to care every shift, bag placed every morning; to be changed monthly and as needed for occlusion or leakage, drainage bag to be changed once a day for care ... output should be monitored every shift. Enhanced Barrier Precaution: Applied as necessary for control.</p> <p>Medication ordered include 5 milligram (mg) 1 tablet by daily for Prostatic Hyperplasia (), : 0.4 mg 1 capsule in the evening for</p> <p>Record review of Resident #7 's Admission Minimum Data Set (MDS) dated revealed: The resident has a brief interview mental status score of 00, indicating severe . Functionally, the resident has upper extremity but is independent in lower extremities, using a walker and wheelchair. The resident has an is not on a toileting program, and is frequently . Active diagnoses include insufficiency, and other -related conditions.</p> <p>Record review of Resident #7 's Care Plans Reference date and revised on revealed: The resident has an due to a , and the goal is to prevent -related . Interventions include positioning the bag below the and away from the door, checking for kinks in the</p>	F 684		

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F 684	<p>Continued From page 8</p> <p>tubing each shift, monitoring intake and output, and observing for signs of discomfort or</p> <p>The resident has behavior issues related to noncompliance with the treatment regimen, including putting the tube around the _____ and allowing the bag to drag on the floor, despite education and redirection. The goal for this behavior is to reduce episodes and avoid adverse consequences. Interventions include _____, the resident's needs, educating the family and caregivers on coping strategies, explaining procedures, discussing inappropriate behaviors, and intervening as needed to ensure the resident's safety and comfort.</p> <p>Interview on _____ at 02:56 PM, Staff X, LPN acknowledged that having the _____'s drainage bag on the floor was unacceptable due to the increased risk of _____ and dislodgement.</p> <p>On _____ at 3:06 PM, Staff T, Certified Nurse assistant and the Director of Nursing (DON) revealed they also made efforts to educate the resident about the risks of having the _____ on the floor and _____ explained that the resident was _____ and did not consistently follow their instructions regarding _____ care. During this interview Resident # 7 was observed ambulating unsteadily in the hallway holding the _____ in his _____. Staff T assisted the resident to his room and placed the _____'s drainage bag on the wheelchair.</p> <p>Resident # 8</p> <p>On _____ at 10:20 AM, Resident #8 was</p>	F 684			

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F 684	<p>Continued From page 9</p> <p>observed exiting the elevator with the drainage bag on his , and the tubing on the wheelchair's wheels increasing the risk for dislodgement and if the is unintentionally pulled out.</p> <p>On at 03:40 PM, Resident #8 was observed returning to his room after playing bingo, the bag and tubing were positioned in close proximity of the wheelchair's wheels increasing the risk for dislodgement of . The DON was present and was shown the concerns; and revealed sometimes the resident move the around.</p> <p>Review of the medical records for Resident #8 revealed the resident was initially admitted to the facility on . Clinical diagnoses include but not limited to: of of and , and prostatic hyperplasia without lower tract symptoms.</p> <p>Review of Resident # 8's Physician's Orders Sheet for revealed orders that include, care is required every shift, to be changed monthly or as needed for occlusion or leakage. Medications included 5 mg daily for and 20 mg daily as a</p> <p>Record review of Resident #8's Admission Minimum Data Set (MDS) dated revealed: The resident's brief interview mental status score is 13, indicating mild . The resident does not have in upper or lower extremities and uses a wheelchair. The resident has an and is not on a or toileting</p>	F 684			

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F 684	Continued From page 10 program. Active diagnoses include _____ and _____ prostatic hyperplasia without lower _____ tract symptoms. Record review of Resident #8 's Care Plans Reference date _____ and revised on _____ revealed focuses on managing the resident's _____ due to _____ and _____. The goals are to prevent _____-related _____ and avoid _____. Key interventions include changing the _____ as needed, positioning the _____ bag properly, checking tubing for kinks, monitoring intake/output, and documenting symptoms of discomfort or _____.resident sometimes lets the _____ bag drag on the floor. The goal is to reduce these behaviors and prevent adverse consequences. Staff should monitor behavioral episodes and document potential causes to help manage future occurrences. On _____ at 3:10 PM, the DON was asked about the usage of _____ drainage bag for both residents. The DON revealed when the _____ bag is in place the residents tried to remove it, but she will attempt to do so again.	F 684			
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart.	F 756			

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F 756	<p>Continued From page 11</p> <p>§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.</p> <p>(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.</p> <p>(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.</p> <p>(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.</p> <p>§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations records reviewed and interviews; the facility failed to ensure Drug Regimen Reviews were completed for one (Resident # 13) out of three residents reviewed as evidenced by Resident #13 who was admitted to the facility has been receiving a combination of medication,</p> <p>relaxer, and</p>	F 756			

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F 756	<p>Continued From page 12</p> <p>medication that has the potential to cause serious interactions and side effects has not received the Drug Regimen Review within the required time frame.</p> <p>The findings include.</p> <p>On at 10:15 AM Resident # 13 was observed smoking at the designated smoking patio located on the second floor interacting with staff.</p> <p>On at 11:19 AM Resident #13 was observed in the elevator going up to the third floor. It was noted that another resident made fat shaming remarks directed at Resident #13. Who did not respond and held her down.</p> <p>On at 9:35 AM Resident # 13 was observed on the smoking patio and interacted with staff.</p> <p>On at 9:50 AM Resident #13 was in her room, and was compliant with taking her medications during medication administration observation. After the nurse left the room; Resident # 13 stated: "I get a lot of medications. I like to be in my room by myself sometimes because I get sleepy, I drink a lot of coffee when I go downstairs to smoke. I am doing good now, I came from a Wheelchair to a walker. I was getting a medicine that make me so sleepy, and I am happy I don't get it anymore. I am here because I got hit by a car in Orlando and this is the only place that will take me in.</p> <p>Record review revealed Resident #13 was initially admitted to the facility on and readmitted on . Resident #13's clinical</p>	F 756			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/30/2025
FORM APPROVED
OMB NO. 0938-0391

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F 756	<p>Continued From page 13</p> <p>diagnoses include: of the first , specifically a subsequent encounter for with routine healing, of the II and a range of other conditions affecting her physical and mental health including treatment for and type 2</p> <p>Resident #13's medications ordered include but not limited: 45 mg (milligrams) at bedtime (medication). Oral Tablet 300 mg; one tablet by two times a day (0800 and 1700) for (medication). Oral Tablet 1 mg one tablet by two times a day (0800 and 1700) for (an medication). (a relaxer) Oral Capsule 100 mg, one capsule by one time a day for 1000 mg, one tablet orally two times a day for and Oral Solution 250 mg /5 ml(milligrams per milliliters)10 ml by three times a day for</p> <p>Review of Resident #13's Minimum Data Set (MDS) Quarterly Assessment dated revealed Resident #13 is , show minimal or no , showed no behaviors and (and). Section for High-Risk Medications indicated the resident is taking high risk medications that include and that are being taken routinely. The MDS indicated no GDR (Gradual Dose Reduction) had been attempted and section for Medication Follow-up documented: Not assessed/no information.</p>	F 756		

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F 756	Continued From page 14 During an interview on _____ at 2:16 PM; the Psychiatrist was asked how frequently he visits the _____ facility to see Resident #13 and if he receive report from staff and interact with the resident. He stated: "I physically see all the residents and I see [Resident #13] every quarter like I see all my patients. I think I saw her in _____." The Psychiatrist was asked to explain Resident #13's current Medication Regimnet which include: _____ and _____ and if it is necessary for the resident to be taking this combination of high-risk medications based on the resident's history that include _____. The Psychiatrist stated: "She has calmed down and the medications are effective, when I go to see her she is doing pretty good, and she is able to tell me how she is doing." When asked if any attempts were made to a GDR on any of the medications. He stated: "We are always getting recommendations...we declined attempting GDR because she does need the dosage she is taking, and we usually do the GDR once if the pharmacy recommend, only because we are forced/so we attempt." The Psychiatrist about the high dosage of _____ that Resident #13 is taking. He asked: "What is the dose?" The surveyor informed him that the resident is taking _____ 300 mg twice daily; the Psychiatrist was also asked about the _____ 1 mg twice per day and the _____ 45 mg. The Psychiatrist stated: "I am wondering why I gave her the _____ and _____, she may have been agitated and depressed; based on her behaviors at first when she was admitted because she was irritable and now she is laid _____, and the last time I saw her she was doing better. I think that is why I have her each of these medications instead	F 756			

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F 756	<p>Continued From page 15</p> <p>of only the . I think I will decrease the dose and ."</p> <p>On at 4:35 PM, interview with the Director of Nursing (DON); she revealed between and the Resident was observed drooling and sleeping, and could not do and was not able to hold her cigarette. The DON revealed she called and informed the Psychiatrist that the needed to be discontinued, and he discontinued the on</p> <p>Review of the Psychiatrist visit notes dated documented D/C (discontinue) all</p> <p>Review of Resident #13's Medication Regimen Review (MRR) with the DON revealed a recommendation documentation dated indicating: "Federal guidelines state psychopharmacological drugs should have an attempt at a gradual dose reduction (GDR) twice per year for the first year in 2 different quarters with 1 month between attempts, then annually thereafter, when used to manage behavior, stabilize or treat psych. This resident has been taking 300 mg and 1 mg. Could we attempt a dose reduction(s) at this time to verify this resident is on the lowest possible dose? If not, please indicate response below: RESPONSE: previous, in facility, GDR failure OR Use is in accordance with relevant current standards of practice. Both options require clinical rationale for continuing by physician; stated below OR documented in the clinical record." The response was signed by the doctor on. Further review of the Medication Regimen Review Log with the DON revealed no reviews completed for-</p>	F 756			

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F 756	Continued From page 16 The DON acknowledged the concerns.	F 756			

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N 000	<p>INITIAL COMMENTS</p> <p>An unannounced survey for Complaint numbers 2025003445 and 2025003849 were conducted to _____ at Gardens Nursing & Rehabilitation Center. The complaint allegation were substantiated. The facility had deficiencies at the time of this survey.</p>	N 000		
N 072 SS=D	<p>59A-4.109(2), FAC; Comprehensive Care Plans</p> <p>59A-4.109 FAC</p> <p>(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.</p> <p>This Statute or Rule is not met as evidenced by: Based on observations, record review and interviews, the facility failed to develop and implement a discharge care plan for one (Resident # 1) out of three resident whose discharge care plans were reviewed. There were 106 residents residing in the facility at the time of this survey.</p> <p>The findings included:</p> <p>Record review of Resident # 1's clinical records revealed the resident was admitted to the facility on _____ and discharged on _____ Clinical diagnoses include Displaced Tri malleolar of Right Lower _____ Subsequent</p>	N 072		

AHCA Form 3020-0001 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X8) DATE /25
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N 072	<p>Continued From page 1</p> <p>Encounter for Closed with Routine Healing, Encounter for Other Orthopedic Aftercare.</p> <p>Record review of orders dated indicated the resident was to be discharged home with family on .</p> <p>Review of the Admission Minimum Date Set (MDS) Section C for Patterns dated revealed the Brief Interview of Mental Status () summary score was 07 out of 15 indicating severe . The section for Functional Abilities dated revealed the resident was independent for eating, oral hygiene, toileting hygiene, upper body and personal hygiene. The resident needed partial/ for shower/bath and lower body and needed substantial/maximal assistance for putting on/taking off footwear.</p> <p>Record review of the overall Discharge Summary revealed the resident is to be discharged home with family. No medical equipment needed, or home health requested. The resident choice to be discharged on .</p> <p>Review of the Admission Baseline Care Plan dated indicated on the Initial Admission/Discharge: Remain in the facility.</p> <p>Review of the MDS Discharge Return Non- Information dated revealed the resident was discharged to home/community.</p> <p>Review of the Nursing Home Transfer and Discharge Notice dated /2025 revealed the facility gave the resident a 30-day notice to vacate the facility due to the resident's unpaid bill</p>	N 072		
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N 072	<p>Continued From page 2</p> <p>for services received at the facility after reasonable and appropriate notice to pay</p> <p>Based on observations, record review and interviews, the facility failed to develop and implement a discharge care plan for one (Resident # 1) out of three resident whose discharge care plans were reviewed. There were 106 residents residing in the facility at the time of this survey.</p> <p>The findings included:</p> <p>Record review of Resident # 1's clinical records revealed the resident was admitted to the facility on _____ and discharged on _____ Clinical diagnoses include Displaced Tri malleolar of Right Lower _____. Subsequent Encounter for Closed _____ with Routine Healing, Encounter for Other Orthopedic Aftercare.</p> <p>Record review of orders dated _____ indicated the resident was to be discharged home with family on _____ Review of the Admission Minimum Date Set (MDS) Section C for _____ Patterns dated _____ revealed the Brief Interview of Mental Status (_____) summary score was 07 out of 15 indicating severe _____. The section for Functional Abilities dated _____ revealed the resident was independent for eating, oral hygiene, toileting hygiene, upper body _____ and personal hygiene. The resident needed partial/_____ for shower/bath and lower body _____ and needed substantial/maximal assistance for putting on/taking off footwear.</p> <p>Record review of the overall Discharge Summary</p>	N 072		

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N 072	<p>Continued From page 3</p> <p>revealed the resident is to be discharged home with family. No medical equipment needed, or home health requested. The resident choice to be discharged on .</p> <p>Review of the Admission Baseline Care Plan dated indicated on the Initial Admission/Discharge: Remain in the facility.</p> <p>Review of the MDS Discharge Return Non- Information dated revealed the resident was discharged to home/community.</p> <p>Review of the Nursing Home Transfer and Discharge Notice dated /20205 revealed the facility gave the resident a 30-day notice to vacate the facility due to the resident's unpaid bill for services received at the facility after being given reasonable and appropriate notice to pay.</p> <p>Interview on at 1:35 PM the Social Services Director revealed she is not in charge of the development of care plans, and she is in charge of the Nursing Home Transfer and Discharge Notice.</p> <p>Interview on at 1:50 PM; the MDS Coordinator revealed she is in charge of the development of care plans. The MDS Coordinator acknowledge the resident did not have any discharge care plan.</p> <p>Record review of the facility's Policies and Procedures for Care Plan-Comprehensive with effective date revealed Overview: An individualized comprehensive care plan that includes measurable objectives and timetable to meet the resident's medical, nursing, mental and needs is developed for each</p>	N 072		

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N 072	<p>Continued From page 4</p> <p>resident. Policy: Our facility's care plan planning/interdisciplinary team, in coordination with the resident, his/her family or representative (sponsor, develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. Procedure: 5- The resident's comprehensive care plan is developed within seven (7) days of the completion of the resident's comprehensive assessment...</p> <p>Class III Based on observation, interview and record review the facility failed to ensure _____ are secure for two (Residents #7, and Resident #8) out of two residents reviewed for _____. As evidenced by _____ Resident #7's _____ was observed in the hallway carry his _____ bag in his _____ and at times placing it on the floor. Resident # 8 was observed with the _____'s drainage bag on his _____, and the tubing on the wheelchair's wheels. These deficient practices increases the risk for related urological _____ if the _____ is unintentionally pulled resulting in dislodgement.</p> <p>The findings include:</p> <p>Resident #7</p> <p>On _____ at 10:05 AM, Resident#7 was observed in the hallway with his _____ resting on his _____. At the time of the observation, there was no privacy bag in use to cover the _____. (Photographic evidence) On _____ at 11:28 AM, Resident#7's</p>	N 072		
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N 072	<p>Continued From page 5</p> <p>_____ was observed on the floor, the _____ was not properly secured or positioned. A staff member was noted performing 15-minute checks on residents, and did not notice the _____ bag on the floor (Photographic evidence)</p> <p>On _____ at 03:00 PM, Staff X, Licensed Practical Nurse (LPN), entered Resident #7's room. The nurse picked up the _____ bag and placed it on the side of the bed while the resident was sitting in the wheelchair; if the resident were to roll the wheelchair, there was a potential risk of the _____ being dislodged.</p> <p>Review of the medical records for Resident #7 revealed the resident was initially admitted to the facility on _____. Clinical diagnoses include but not limited to _____ of the _____ unspecified _____ obstruction, _____ prostatic hyperplasia without lower _____ tract symptoms and _____.</p> <p>Review of Resident#7's Physician's Orders for _____ included but not limited to _____ care every shift, _____ bag placed every morning; _____ to be changed monthly and as needed for occlusion or leakage, drainage bag to be changed once a day for _____ care ... output should be monitored every shift. Enhanced Barrier Precaution: Applied as necessary for control.</p> <p>Medication ordered include _____ 5 milligram (mg) 1 tablet by _____ daily for _____ Prostatic Hyperplasia (_____), _____ : 0.4 mg 1 capsule in the evening for _____.</p> <p>Record review of Resident #7 's Admission</p>	N 072		
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N 072	<p>Continued From page 6</p> <p>Minimum Data Set (MDS) dated _____ revealed: The resident has a brief interview mental status score of 00, indicating severe _____. Functionally, the resident has _____ upper extremity _____ but is independent in lower extremities, using a walker and wheelchair. The resident has an _____, is not on a toileting program, and is frequently _____. Active diagnoses include _____ insufficiency, _____, and other _____-related conditions.</p> <p>Record review of Resident #7 's Care Plans Reference date _____ and revised on _____ revealed: The resident has an _____ due to a _____, and the goal is to prevent _____-related _____. Interventions include positioning the _____ bag below the _____ and away from the door, checking for kinks in the tubing each shift, monitoring intake and output, and observing for signs of discomfort or _____. The resident has behavior issues related to noncompliance with the treatment regimen, including putting the _____ tube around the _____ and allowing the bag to drag on the floor, despite education and redirection. The goal for this behavior is to reduce episodes and avoid adverse consequences. Interventions include _____ the resident's needs, educating the family and caregivers on coping strategies, explaining procedures, discussing inappropriate behaviors, and intervening as needed to ensure the resident's safety and comfort.</p> <p>Interview on _____ at 02:56 PM, Staff X, LPN acknowledged that having the _____'s drainage bag on the floor was _____</p>	N 072		

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N 072	<p>Continued From page 7</p> <p>unacceptable due to the increased risk of and dislodgement.</p> <p>On at 3:06 PM, Staff T, Certified Nurse assistant and the Director of Nursing (DON) revealed they also made efforts to educate the resident about the risks of having the on the floor and explained that the resident was and did not consistently follow their instructions regarding care. During this interview Resident # 7 was observed ambulating unsteadily in the hallway holding the in his . Staff T assisted the resident to his room and placed the 's drainage bag on the wheelchair.</p> <p>Resident # 8</p> <p>On at 10:20 AM, Resident #8 was observed exiting the elevator with the drainage bag on his , and the tubing on the wheelchair's wheels increasing the risk for dislodgement and if the is unintentionally pulled out.</p> <p>On at 03:40 PM, Resident #8 was observed returning to his room after playing bingo, the bag and tubing were positioned in close proximity of the wheelchair's wheels increasing the risk for dislodgement of the . The DON was present and was shown the concerns; and revealed sometimes the resident move the around.</p> <p>Review of the medical records for Resident #8 revealed the resident was initially admitted to the facility on . Clinical diagnoses include but not limited to: of and and</p>	N 072			

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N 072	<p>Continued From page 8</p> <p>prostatic hyperplasia without lower tract symptoms.</p> <p>Review of Resident # 8's Physician's Orders Sheet for revealed orders that include, care is required every shift, to be changed monthly or as needed for occlusion or leakage. Medications included 5 mg daily for and 20 mg daily as a</p> <p>Record review of Resident #8 's Admission Minimum Data Set (MDS) dated revealed: The resident's brief interview mental status score is 13, indicating mild . The resident does not have in upper or lower extremities and uses a wheelchair. The resident has an and is not on a , or toileting program. Active diagnoses include and prostatic hyperplasia without lower tract symptoms.</p> <p>Record review of Resident #8 's Care Plans Reference date and revised on revealed focuses on managing the resident's due to and . The goals are to prevent -related and avoid . Key interventions include changing the as needed, positioning the bag properly, checking tubing for kinks, monitoring intake/output, and documenting symptoms of discomfort or resident sometimes lets the bag drag on the floor. The goal is to reduce these behaviors and prevent adverse consequences. Staff should monitor behavioral episodes and document potential causes to help manage future occurrences.</p>	N 072		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 111353	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/27/2025
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NAME OF PROVIDER OR SUPPLIER GARDENS NURSING AND REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 190 NE 191ST STREET MIAMI, FL 33161
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N 201	Continued From page 9	N 201		
N 201 SS=D	<p>400.022(1)(i), FS Right to Adequate and Appropriate Health Care</p> <p>(i) 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.</p> <p>This Statute or Rule is not met as evidenced by: Based on observation, interview and record review the facility failed to provide adequate and appropriate healthcare to prevent the potential risk of _____ dislodgement for two (Residents #7, and Resident #8) out of two residents reviewed for _____. As evidenced by Resident #7's was observed in the hallway carrying his _____ bag in his _____ and at times placing it on the floor. Resident # 8 was observed with the _____'s drainage bag on his _____, and the tubing on the wheelchair's wheels. These deficient practices increases the risk for _____ related urological _____ if the _____ is unintentionally pulled resulting in dislodgement.</p> <p>The findings include:</p> <p>Resident #7</p> <p>On _____ at 10:05 AM, Resident#7 was observed in the hallway with his _____ resting on his _____. At the time of the _____</p>	N 201		

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N 201	<p>Continued From page 10</p> <p>observation, there was no privacy bag in use to cover the . (Photographic evidence) On . . . at 11:28 AM, Resident#7's was observed on the floor, the was not properly secured or positioned. A staff member was noted performing 15-minute checks on residents, and did not notice the bag on the floor (Photographic evidence)</p> <p>On at 03:00 PM, Staff X, Licensed Practical Nurse (LPN), entered Resident #7's room. The nurse picked up the bag and placed it on the side of the bed while the resident was sitting in the wheelchair; if the resident were to roll the wheelchair, there was a potential risk of the being dislodged.</p> <p>Review of the medical records for Resident #7 revealed the resident was initially admitted to the facility on . Clinical diagnoses include but not limited to of the unspecified , prostatic hyperplasia without lower tract symptoms and</p> <p>Review of Resident#7's Physician's Orders for included but not limited to care every shift, bag placed every morning; to be changed monthly and as needed for occlusion or leakage, drainage bag to be changed once a day for care ... output should be monitored every shift. Enhanced Barrier Precaution: Applied as necessary for control.</p> <p>Medication ordered include 5 milligram (mg) 1 tablet by daily for Prostatic Hyperplasia (), : 0.4</p>	N 201		
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N 201	<p>Continued From page 11</p> <p>mg 1 capsule in the evening for</p> <p>Record review of Resident #7 's Admission Minimum Data Set (MDS) dated revealed: The resident has a brief interview mental status score of 00, indicating severe . Functionally, the resident has . upper extremity . but is independent in lower extremities, using a walker and wheelchair. The resident has an . , is not on a toileting program, and is frequently . Active diagnoses include . insufficiency, . , and other -related conditions.</p> <p>Record review of Resident #7 's Care Plans Reference date and revised on revealed: The resident has an due to a . , and the goal is to prevent -related . Interventions include positioning the . bag below the . and away from the door, checking for kinks in the tubing each shift, monitoring intake and output, and observing for signs of discomfort or . The resident has behavior issues related to noncompliance with the treatment regimen, including putting the tube around the and allowing the bag to drag on the floor, despite education and redirection. The goal for this behavior is to reduce episodes and avoid adverse consequences. Interventions include . the resident's needs, educating the family and caregivers on coping strategies, explaining procedures, discussing inappropriate behaviors, and intervening as needed to ensure the resident's safety and comfort.</p>	N 201		

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N 201	<p>Continued From page 12</p> <p>Interview on _____ at 02:56 PM, Staff X, LPN acknowledged that having the _____'s drainage bag on the floor was unacceptable due to the increased risk of _____ and dislodgement.</p> <p>On _____ at 3:06 PM, Staff T, Certified Nurse assistant and the Director of Nursing (DON) revealed they also made efforts to educate the resident about the risks of having the _____ on the floor and _____ explained that the resident was _____ and did not consistently follow their instructions regarding _____ care. During this interview Resident # 7 was observed ambulating unsteadily in the hallway holding the _____ in his _____. Staff T assisted the resident to his room and placed the _____'s drainage bag on the wheelchair.</p> <p>Resident # 8</p> <p>On _____ at 10:20 AM, Resident #8 was observed exiting the elevator with the _____ drainage bag on his _____, and the tubing on the wheelchair's wheels increasing the risk for dislodgement and _____ if the _____ is unintentionally pulled out.</p> <p>On _____ at 03:40 PM, Resident #8 was observed returning to his room after playing bingo, the _____ bag and tubing were positioned in close proximity of the wheelchair's wheels increasing the risk for dislodgement of the _____. The DON was present and _____ was shown the concerns; and revealed sometimes the resident move the _____ around.</p> <p>Review of the medical records for Resident #8</p>	N 201		
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N 201	<p>Continued From page 13</p> <p>revealed the resident was initially admitted to the facility on . Clinical diagnoses include but not limited to: of of and and prostatic hyperplasia without lower tract symptoms.</p> <p>Review of Resident # 8's Physician's Orders Sheet for revealed orders that include, care is required every shift, to be changed monthly or as needed for occlusion or leakage. Medications included 5 mg daily for and 20 mg daily as a</p> <p>Record review of Resident #8 's Admission Minimum Data Set (MDS) dated revealed: The resident's brief interview mental status score is 13, indicating mild . The resident does not have in upper or lower extremities and uses a wheelchair. The resident has an and is not on a , or toileting program. Active diagnoses include and prostatic hyperplasia without lower tract symptoms.</p> <p>Record review of Resident #8 's Care Plans Reference date and revised on revealed focuses on managing the resident's due to and . The goals are to prevent -related and avoid . Key interventions include changing the as needed, positioning the bag properly, checking tubing for kinks, monitoring intake/output, and documenting symptoms of discomfort or ...resident sometimes lets the bag drag on the floor. The goal is to reduce these behaviors and prevent</p>	N 201		
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N 201	Continued From page 14 adverse consequences. Staff should monitor behavioral episodes and document potential causes to help manage future occurrences. Class III	N 201		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105765	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/27/2025
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F 000	INITIAL COMMENTS An unannounced survey for Complaint numbers 2025003445 and 2025003849 were conducted to _____ at Gardens Nursing & Rehabilitation Center. The complaint allegation were substantiated. The facility was not in compliance with 42 CFR 483. Requirements for Long Term Care Facilities. The following is a description of the non-compliance.	F 000			
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	F 656			

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 656	<p>Continued From page 1</p> <p>findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>()In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(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.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(iii) Be culturally-competent and -informed. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, record review and interviews, the facility failed to develop and implement a discharge care plan for one (Resident # 1) out of three resident whose discharge care plans were reviewed. There were 106 residents residing in the facility at the time of this survey.</p> <p>The findings included:</p> <p>Record review of Resident # 1's clinical records revealed the resident was admitted to the facility on _____ and discharged on _____</p> <p>Clinical diagnoses include Displaced Tri malleolar of Right Lower _____, Subsequent Encounter for Closed _____ with Routine Healing, Encounter for Other Orthopedic</p>	F 656	<p>Facility denies and disputes the validity of this citation and completes this POC solely</p> <p>to meet the requirements of State licensure and Federal regulations. Facility further denies any and all statements, acknowledgements, confirmations, or comments attributed to facility staff as strictly hearsay.</p> <p>1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>Resident # 1 was discharged home</p>		

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F 656	<p>Continued From page 2 Aftercare.</p> <p>Record review of orders dated _____ indicated the resident was to be discharged home with family on _____.</p> <p>Review of the Admission Minimum Date Set (MDS) Section C for _____ Patterns dated _____ revealed the Brief Interview of Mental Status (_____) summary score was 07 out of 15 indicating severe _____. The section for Functional Abilities dated _____ revealed the resident was independent for eating, oral hygiene, toileting hygiene, upper body _____ and personal hygiene. The resident needed partial/ _____ for shower/bath and lower body _____ and needed substantial/maximal assistance for putting on/taking off footwear.</p> <p>Record review of the overall Discharge Summary revealed the resident is to be discharged home with family. No medical equipment needed, or home health requested. The resident choice to be discharged on _____.</p> <p>Review of the Admission Baseline Care Plan dated _____ indicated on the Initial Admission/Discharge: Remain in the facility.</p> <p>Review of the MDS Discharge Return Non- _____ Information dated _____ revealed the resident was discharged to home/community.</p> <p>Review of the Nursing Home Transfer and Discharge Notice dated _____ /2025 revealed the facility gave the resident a 30-day notice to vacate the facility due to the resident's unpaid bill</p>	F 656	<p>How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken;</p> <p>Quality review by the MDS Coordinator/Social Service Director/designee of current residents to ensure a discharge care plan is developed within 48 hours of admission/re-admission to be completed by _____.</p> <p>(3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur;</p> <p>MDS Coordinator/Social Service Director re-educated by the Chief Clinical Reimbursement Officer on the components of this regulation and to ensure residents have a discharge care plan developed within 48 hours of admission/re-admission to be completed by _____.</p> <p>(4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place;</p> <p>MDS Coordinator/Social Service Director / designee to conduct ongoing quality monitoring through morning clinical meeting to ensure a discharge care plan is developed within 48 hours of admission /re-admission 3 x weekly x 2 weeks, 2 x</p>	

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F 656	<p>Continued From page 3</p> <p>for services received at the facility after reasonable and appropriate notice to pay</p> <p>Based on observations, record review and interviews, the facility failed to develop and implement a discharge care plan for one (Resident # 1) out of three resident whose discharge care plans were reviewed. There were 106 residents residing in the facility at the time of this survey.</p> <p>The findings included:</p> <p>Record review of Resident # 1's clinical records revealed the resident was admitted to the facility on _____ and discharged on _____ Clinical diagnoses include Displaced Tri malleolar of Right Lower _____, Subsequent Encounter for Closed _____ with Routine Healing, Encounter for Other Orthopedic Aftercare.</p> <p>Record review of orders dated _____ indicated the resident was to be discharged home with family on _____.</p> <p>Review of the Admission Minimum Date Set (MDS) Section C for _____ Patterns dated _____ revealed the Brief Interview of Mental Status (_____) summary score was 07 out of 15 indicating severe _____. The section for Functional Abilities dated _____ revealed the resident was independent for eating, oral hygiene, toileting hygiene, upper body _____ and personal hygiene. The resident needed partial/ _____ for shower/bath and lower body _____ and needed substantial/maximal assistance for putting on/taking off footwear.</p>	F 656	<p>weekly x 2 weeks then weekly and PRN as indicated.</p> <p>The findings of these quality reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly x 2 months or until substantial compliance is met then quarterly ongoing. Schedule to be modified PRN based on findings.</p>		

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F 656	<p>Continued From page 4</p> <p>Record review of the overall Discharge Summary revealed the resident is to be discharged home with family. No medical equipment needed, or home health requested. The resident choice to be discharged on _____.</p> <p>Review of the Admission Baseline Care Plan dated _____ indicated on the Initial Admission/Discharge: Remain in the facility.</p> <p>Review of the MDS Discharge Return Non-_____ Information dated _____ revealed the resident was discharged to home/community.</p> <p>Review of the Nursing Home Transfer and Discharge Notice dated _____/20205 revealed the facility gave the resident a 30-day notice to vacate the facility due to the resident's unpaid bill for services received at the facility after being given reasonable and appropriate notice to pay.</p> <p>Interview on _____ at 1:35 PM the Social Services Director revealed she is not in charge of the development of care plans, and she is in charge of the Nursing Home Transfer and Discharge Notice.</p> <p>Interview on _____ at 1:50 PM; the MDS Coordinator revealed she is in charge of the development of care plans. The MDS Coordinator acknowledge the resident did not have any discharge care plan.</p> <p>Record review of the facility's Policies and Procedures for Care Plan-Comprehensive with effective date _____ revealed Overview: An individualized comprehensive care plan that _____</p>	F 656			

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F 656	Continued From page 5 includes measurable objectives and timetable to meet the resident's medical, nursing, mental and needs is developed for each resident. Policy: Our facility's care plan planning/interdisciplinary team, in coordination with the resident, his/her family or representative (sponsor, develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. Procedure: 5- The resident's comprehensive care plan is developed within seven (7) days of the completion of the resident's comprehensive assessment.	F 656		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure _____ are secure for two (Residents #7, and Resident #8) out of two residents reviewed for _____. As evidenced by Resident #7's was observed in the hallway carry his _____ bag in his _____ and at times placing it on the floor. Resident # 8 was observed with the _____'s drainage bag on his _____, and the tubing on the wheelchair's wheels. These	F 684	Facility denies and disputes the validity of this citation and completes this POC solely to meet the requirements of State licensure and Federal regulations. Facility further denies any and all statements, acknowledgements, confirmations, or comments attributed to facility staff as strictly hearsay.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER GARDENS NURSING AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 190 NE 191ST STREET MIAMI, FL 33161	
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F 684	<p>Continued From page 6</p> <p>deficient practices increases the risk for related urological if the is unintentionally pulled resulting in dislodgement.</p> <p>The findings include:</p> <p>Resident #7</p> <p>On at 10:05 AM, Resident#7 was observed in the hallway with his resting on his . At the time of the observation, there was no privacy bag in use to cover the . (Photographic evidence)</p> <p>On at 11:28 AM, Resident#7's was observed on the floor, the was not properly secured or positioned. A staff member was noted performing 15-minute checks on residents, and did not notice the bag on the floor (Photographic evidence)</p> <p>On at 03:00 PM, Staff X, Licensed Practical Nurse (LPN), entered Resident #7's room. The nurse picked up the bag and placed it on the side of the bed while the resident was sitting in the wheelchair; if the resident were to roll the wheelchair, there was a potential risk of the being dislodged.</p> <p>Review of the medical records for Resident #7 revealed the resident was initially admitted to the facility on . Clinical diagnoses include but not limited to of the unspecified obstruction, prostatic hyperplasia without lower tract symptoms and</p>	F 684	<p>1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>Resident #7 The drainage bag was properly placed on the frame of the bed by the Director of Nursing Resident #7 did not suffer any adverse effects r/t the drainage bag being on the floor.</p> <p>Resident #8 Nursing staff to provide a bag when out of bed to mitigate risk of tubing getting caught in the wheelchair -wheel spokes and so the resident does not place the drainage bag on his as of</p> <p>How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken;</p> <p>Quality review by the DON/designee of current residents of residents with an to ensure are secure and the drainage bag is not on the floor and the drainage bag is covered, to be completed by</p> <p>(3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur;</p> <p>Current licensed nurses are re-educated by the DON/designee on the components</p>	

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F 684	<p>Continued From page 7</p> <p>Review of Resident#7's Physician's Orders for included but not limited to care every shift, bag placed every morning; to be changed monthly and as needed for occlusion or leakage, drainage bag to be changed once a day for care ... output should be monitored every shift. Enhanced Barrier Precaution: Applied as necessary for control.</p> <p>Medication ordered include 5 milligram (mg) 1 tablet by daily for Prostatic Hyperplasia (), : 0.4 mg 1 capsule in the evening for</p> <p>Record review of Resident #7 's Admission Minimum Data Set (MDS) dated revealed: The resident has a brief interview mental status score of 00, indicating severe . Functionally, the resident has upper extremity but is independent in lower extremities, using a walker and wheelchair. The resident has an is not on a toileting program, and is frequently . Active diagnoses include insufficiency, and other -related conditions.</p> <p>Record review of Resident #7 's Care Plans Reference date and revised on revealed: The resident has an due to a , and the goal is to prevent -related . Interventions include positioning the bag below the and away from the door, checking for kinks in the</p>	F 684	<p>of this regulation and to ensure are secure, the drainage bag is not on the floor and the drainage bag is covered to be completed by</p> <p>(4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place;</p> <p>DON /designee to conduct ongoing quality monitoring through visual observation of residents with an to ensure are secure, the drainage bag is not on the floor and the drainage bag is covered 3 x weekly x 2 weeks, 2 x weekly x 2 weeks then weekly and PRN as indicated.</p> <p>The findings of these quality reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly x 2 months or until substantial compliance is met then quarterly ongoing. Schedule to be modified PRN based on findings.</p>	

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F 684	<p>Continued From page 8</p> <p>tubing each shift, monitoring intake and output, and observing for signs of discomfort or</p> <p>The resident has behavior issues related to noncompliance with the treatment regimen, including putting the tube around the _____ and allowing the bag to drag on the floor, despite education and redirection. The goal for this behavior is to reduce episodes and avoid adverse consequences. Interventions include _____, the resident's needs, educating the family and caregivers on coping strategies, explaining procedures, discussing inappropriate behaviors, and intervening as needed to ensure the resident's safety and comfort.</p> <p>Interview on _____ at 02:56 PM, Staff X, LPN acknowledged that having the _____'s drainage bag on the floor was unacceptable due to the increased risk of _____ and dislodgement.</p> <p>On _____ at 3:06 PM, Staff T, Certified Nurse assistant and the Director of Nursing (DON) revealed they also made efforts to educate the resident about the risks of having the _____ on the floor and explained that the resident was _____ and did not consistently follow their instructions regarding _____ care. During this interview Resident # 7 was observed ambulating unsteadily in the hallway holding the _____ in his _____. Staff T assisted the resident to his room and placed the _____'s drainage bag on the wheelchair.</p> <p>Resident # 8</p> <p>On _____ at 10:20 AM, Resident #8 was</p>	F 684			

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F 684	<p>Continued From page 9</p> <p>observed exiting the elevator with the drainage bag on his , and the tubing on the wheelchair's wheels increasing the risk for dislodgement and if the is unintentionally pulled out.</p> <p>On at 03:40 PM, Resident #8 was observed returning to his room after playing bingo, the bag and tubing were positioned in close proximity of the wheelchair's wheels increasing the risk for dislodgement of . The DON was present and was shown the concerns; and revealed sometimes the resident move the around.</p> <p>Review of the medical records for Resident #8 revealed the resident was initially admitted to the facility on . Clinical diagnoses include but not limited to: of and , and prostatic hyperplasia without lower tract symptoms.</p> <p>Review of Resident # 8's Physician's Orders Sheet for revealed orders that include, care is required every shift, to be changed monthly or as needed for occlusion or leakage. Medications included 5 mg daily for and 20 mg daily as a</p> <p>Record review of Resident #8's Admission Minimum Data Set (MDS) dated revealed: The resident's brief interview mental status score is 13, indicating mild . The resident does not have in upper or lower extremities and uses a wheelchair. The resident has an and is not on a or toileting</p>	F 684			

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F 684	Continued From page 10 program. Active diagnoses include _____ and _____ prostatic hyperplasia without lower _____ tract symptoms. Record review of Resident #8 's Care Plans Reference date _____ and revised on _____ revealed focuses on managing the resident's _____ due to _____ and _____. The goals are to prevent _____-related _____ and avoid _____. Key interventions include changing the _____ as needed, positioning the _____ bag properly, checking tubing for kinks, monitoring intake/output, and documenting symptoms of discomfort or _____.resident sometimes lets the _____ bag drag on the floor. The goal is to reduce these behaviors and prevent adverse consequences. Staff should monitor behavioral episodes and document potential causes to help manage future occurrences. On _____ at 3:10 PM, the DON was asked about the usage of _____ drainage bag for both residents. The DON revealed when the _____ bag is in place the residents tried to remove it, but she will attempt to do so again.	F 684			
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart.	F 756			

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F 756	<p>Continued From page 11</p> <p>§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.</p> <p>(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.</p> <p>(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.</p> <p>(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.</p> <p>§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations records reviewed and interviews; the facility failed to ensure Drug Regimen Reviews were completed for one (Resident # 13) out of three residents reviewed as evidenced by Resident #13 who was admitted to the facility has been receiving a combination of medication,</p> <p>relaxer, and</p>	F 756	<p>Facility denies and disputes the validity of this citation and completes this POC solely to meet the requirements of State licensure and Federal regulations. Facility further denies any and all statements, acknowledgements, confirmations, or</p>	

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F 756	<p>Continued From page 12</p> <p>medication that has the potential to cause serious interactions and side effects has not received the Drug Regimen Review within the required time frame.</p> <p>The findings include.</p> <p>On at 10:15 AM Resident # 13 was observed smoking at the designated smoking patio located on the second floor interacting with staff.</p> <p>On at 11:19 AM Resident #13 was observed in the elevator going up to the third floor. It was noted that another resident made fat shaming remarks directed at Resident #13. Who did not respond and held her down.</p> <p>On at 9:35 AM Resident # 13 was observed on the smoking patio and interacted with staff.</p> <p>On at 9:50 AM Resident #13 was in her room, and was compliant with taking her medications during medication administration observation. After the nurse left the room; Resident # 13 stated: "I get a lot of medications. I like to be in my room by myself sometimes because I get sleepy. I drink a lot of coffee when I go downstairs to smoke. I am doing good now, I came from a Wheelchair to a walker. I was getting a medicine that make me so sleepy, and I am happy I don't get it anymore. I am here because I got hit by a car in Orlando and this is the only place that will take me in.</p> <p>Record review revealed Resident #13 was initially admitted to the facility on and readmitted on Resident #13's clinical</p>	F 756	<p>comments attributed to facility staff as strictly hearsay.</p> <p>1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>Resident #13 the psychiatrist reviewed the residents' medications listed below:</p> <p>decreased on from 45mg to 30mg.</p> <p>was decreased from 300mg to 200mg 1mg continue current dose; no changes.</p> <p>How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken;</p> <p>Quality review by the DON/designee of current residents receiving medication(s) to ensure Drug Regimen Reviews are acted upon to include: a medication review by the physician and/or psych provider indicating an attempt at a gradual dose reduction (GDR) and/or a failed GDR to support the rationale for continuing the current medication regimen r/t medications to be completed by</p> <p>(3) What measures will be put into place or what systematic changes you will make</p>	

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F 756	<p>Continued From page 13</p> <p>diagnoses include: of the first , specifically a subsequent encounter for with routine healing, of the II and a range of other conditions affecting her physical and mental health including treatment for and type 2</p> <p>Resident #13's medications ordered include but not limited: 45 mg (milligrams) at bedtime (medication). Oral Tablet 300 mg; one tablet by two times a day (0800 and 1700) for (medication). Oral Tablet 1 mg one tablet by two times a day (0800 and 1700) for (an medication). (a relaxer) Oral Capsule 100 mg, one capsule by one time a day for 1000 mg, one tablet orally two times a day for and Oral Solution 250 mg /5 ml(milligrams per milliliters)10 ml by three times a day for</p> <p>Review of Resident #13's Minimum Data Set (MDS) Quarterly Assessment dated revealed Resident #13 is , show minimal or no , showed no behaviors and (and). Section for High-Risk Medications indicated the resident is taking high risk medications that include and that are being taken routinely. The MDS indicated no GDR (Gradual Dose Reduction) had been attempted and section for Medication Follow-up documented: Not assessed/no information.</p>	F 756	<p>to ensure that the practice does not recur;</p> <p>DON and ADON reeducated by the Chief Nursing Officer on the components of this regulation and to ensure Drug Regimen Reviews are acted upon to include: a medication review by the physician and/or psych provider indicating an attempt at a gradual dose reduction (GDR) and/or a failed GDR to support the rationale for continuing the current medication regimen r/t medications to be completed by</p> <p>(4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place;</p> <p>DON /designee to conduct ongoing quality monitoring through clinical meeting to ensure Drug Regimen Reviews are acted upon to include: a medication review by the physician and/or psych provider indicating an attempt at a gradual dose reduction (GDR) and/or a failed GDR to support the rationale for continuing the current medication regimen r/t medications 3 x weekly x 2 weeks, 2 x weekly x 2 weeks then weekly and PRN as indicated.</p> <p>The findings of these quality reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly x 2 months or until substantial compliance is met then quarterly ongoing. Schedule to be modified PRN based on findings.</p>	

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F 756	Continued From page 14 During an interview on _____ at 2:16 PM; the Psychiatrist was asked how frequently he visits the _____ facility to see Resident #13 and if he receive report from staff and interact with the resident. He stated: "I physically see all the residents and I see [Resident #13] every quarter like I see all my patients. I think I saw her in _____." The Psychiatrist was asked to explain Resident #13's current Medication Regimnet which include: _____ and _____ and if it is necessary for the resident to be taking this combination of high-risk medications based on the resident's history that include _____. The Psychiatrist stated: "She has calmed down and the medications are effective, when I go to see her she is doing pretty good, and she is able to tell me how she is doing." When asked if any attempts were made to a GDR on any of the medications. He stated: "We are always getting recommendations...we declined attempting GDR because she does need the dosage she is taking, and we usually do the GDR once if the pharmacy recommend, only because we are forced/so we attempt." The Psychiatrist about the high dosage of _____ that Resident #13 is taking. He asked: "What is the dose?" The surveyor informed him that the resident is taking _____ 300 mg twice daily; the Psychiatrist was also asked about the _____ 1 mg twice per day and the _____ 45 mg. The Psychiatrist stated: "I am wondering why I gave her the _____ and _____, she may have been agitated and depressed; based on her behaviors at first when she was admitted because she was irritable and now she is laid _____, and the last time I saw her she was doing better. I think that is why I have her each of these medications instead	F 756			

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F 756	<p>Continued From page 15</p> <p>of only the . I think I will decrease the dose and ."</p> <p>On at 4:35 PM, interview with the Director of Nursing (DON); she revealed between and the Resident was observed drooling and sleeping, and could not do and was not able to hold her cigarette. The DON revealed she called and informed the Psychiatrist that the needed to be discontinued, and he discontinued the on</p> <p>Review of the Psychiatrist visit notes dated documented D/C (discontinue) all</p> <p>Review of Resident #13's Medication Regimen Review (MRR) with the DON revealed a recommendation documentation dated indicating: "Federal guidelines state psychopharmacological drugs should have an attempt at a gradual dose reduction (GDR) twice per year for the first year in 2 different quarters with 1 month between attempts, then annually thereafter, when used to manage behavior, stabilize or treat psych. This resident has been taking 300 mg and 1 mg. Could we attempt a dose reduction(s) at this time to verify this resident is on the lowest possible dose? If not, please indicate response below: RESPONSE: previous, in facility, GDR failure OR Use is in accordance with relevant current standards of practice. Both options require clinical rationale for continuing by physician; stated below OR documented in the clinical record." The response was signed by the doctor on. Further review of the Medication Regimen Review Log with the DON revealed no reviews completed for-</p>	F 756			

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F 756	Continued From page 16 The DON acknowledged the concerns.	F 756			

Agency for Health Care Administration

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NAME OF PROVIDER OR SUPPLIER GARDENS NURSING AND REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 190 NE 191ST STREET MIAMI, FL 33161
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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N 000	<p>INITIAL COMMENTS</p> <p>An unannounced survey for Complaint numbers 2025003445 and 2025003849 were conducted to _____ at Gardens Nursing & Rehabilitation Center. The complaint allegation were substantiated. The facility had deficiencies at the time of this survey.</p>	N 000		
N 072 SS=D	<p>59A-4.109(2), FAC; Comprehensive Care Plans</p> <p>59A-4.109 FAC</p> <p>(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.</p> <p>This Statute or Rule is not met as evidenced by: Based on observations, record review and interviews, the facility failed to develop and implement a discharge care plan for one (Resident # 1) out of three resident whose discharge care plans were reviewed. There were 106 residents residing in the facility at the time of this survey.</p> <p>The findings included:</p> <p>Record review of Resident # 1's clinical records revealed the resident was admitted to the facility on _____ and discharged on _____. Clinical diagnoses include Displaced Tri malleolar of Right Lower _____. Subsequent</p>	N 072	<p>Facility denies and disputes the validity of this citation and completes this POC solely _____ to meet the requirements of State licensure and Federal regulations. Facility further denies any and all statements, acknowledgements, confirmations, or comments attributed to facility staff as strictly hearsay.</p> <p>1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p>	

AHCA Form 3020-0001
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Electronically Signed

TITLE

(X8) DATE

/25

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 111353	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/27/2025
NAME OF PROVIDER OR SUPPLIER GARDENS NURSING AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 190 NE 191ST STREET MIAMI, FL 33161		
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N 072	<p>Continued From page 1</p> <p>Encounter for Closed with Routine Healing, Encounter for Other Orthopedic Aftercare.</p> <p>Record review of orders dated indicated the resident was to be discharged home with family on .</p> <p>Review of the Admission Minimum Date Set (MDS) Section C for Patterns dated revealed the Brief Interview of Mental Status () summary score was 07 out of 15 indicating severe . The section for Functional Abilities dated revealed the resident was independent for eating, oral hygiene, toileting hygiene, upper body and personal hygiene. The resident needed partial/ for shower/bath and lower body and needed substantial/maximal assistance for putting on/taking off footwear.</p> <p>Record review of the overall Discharge Summary revealed the resident is to be discharged home with family. No medical equipment needed, or home health requested. The resident choice to be discharged on .</p> <p>Review of the Admission Baseline Care Plan dated indicated on the Initial Admission/Discharge: Remain in the facility.</p> <p>Review of the MDS Discharge Return Non- Information dated revealed the resident was discharged to home/community.</p> <p>Review of the Nursing Home Transfer and Discharge Notice dated /20205 revealed the facility gave the resident a 30-day notice to vacate the facility due to the resident's unpaid bill</p>	N 072	<p>Resident # 1 was discharged home</p> <p>How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken;</p> <p>Quality review by the MDS Coordinator/Social Service Director/designee of current residents to ensure a discharge care plan is developed within 48 hours of admission/re-admission to be completed by .</p> <p>(3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur;</p> <p>MDS Coordinator/Social Service Director re-educated by the Chief Clinical Reimbursement Officer on the components of this regulation and to ensure residents have a discharge care plan developed within 48 hours of admission/re-admission to be completed by .</p> <p>(4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place;</p> <p>MDS Coordinator/Social Service Director / designee to conduct ongoing quality monitoring through morning clinical meeting to ensure a discharge care plan is developed within 48 hours of admission /re-admission 3 x weekly x 2 weeks, 2 x</p>		

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N 072	<p>Continued From page 2</p> <p>for services received at the facility after reasonable and appropriate notice to pay</p> <p>Based on observations, record review and interviews, the facility failed to develop and implement a discharge care plan for one (Resident # 1) out of three resident whose discharge care plans were reviewed. There were 106 residents residing in the facility at the time of this survey.</p> <p>The findings included:</p> <p>Record review of Resident # 1's clinical records revealed the resident was admitted to the facility on _____ and discharged on _____. Clinical diagnoses include Displaced Tri malleolar of Right Lower _____. Subsequent Encounter for Closed _____ with Routine Healing, Encounter for Other Orthopedic Aftercare.</p> <p>Record review of orders dated _____ indicated the resident was to be discharged home with family on _____.</p> <p>Review of the Admission Minimum Date Set (MDS) Section C for _____ Patterns dated _____ revealed the Brief Interview of Mental Status (_____) summary score was 07 out of 15 indicating severe _____. The section for Functional Abilities dated _____ revealed the resident was independent for eating, oral hygiene, toileting hygiene, upper body _____ and personal hygiene. The resident needed partial/ _____ for shower/bath and lower body _____ and needed substantial/maximal assistance for putting on/taking off footwear.</p> <p>Record review of the overall Discharge Summary</p>	N 072	<p>weekly x 2 weeks then weekly and PRN as indicated.</p> <p>The findings of these quality reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly x 2 months or until substantial compliance is met then quarterly ongoing. Schedule to be modified PRN based on findings.</p>		

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N 072	<p>Continued From page 3</p> <p>revealed the resident is to be discharged home with family. No medical equipment needed, or home health requested. The resident choice to be discharged on .</p> <p>Review of the Admission Baseline Care Plan dated indicated on the Initial Admission/Discharge: Remain in the facility.</p> <p>Review of the MDS Discharge Return Non- Information dated revealed the resident was discharged to home/community.</p> <p>Review of the Nursing Home Transfer and Discharge Notice dated /20205 revealed the facility gave the resident a 30-day notice to vacate the facility due to the resident's unpaid bill for services received at the facility after being given reasonable and appropriate notice to pay.</p> <p>Interview on at 1:35 PM the Social Services Director revealed she is not in charge of the development of care plans, and she is in charge of the Nursing Home Transfer and Discharge Notice.</p> <p>Interview on at 1:50 PM; the MDS Coordinator revealed she is in charge of the development of care plans. The MDS Coordinator acknowledge the resident did not have any discharge care plan.</p> <p>Record review of the facility's Policies and Procedures for Care Plan-Comprehensive with effective date revealed Overview: An individualized comprehensive care plan that includes measurable objectives and timetable to meet the resident's medical, nursing, mental and needs is developed for each</p>	N 072		

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N 072	<p>Continued From page 4</p> <p>resident. Policy: Our facility's care plan planning/interdisciplinary team, in coordination with the resident, his/her family or representative (sponsor, develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. Procedure: 5- The resident's comprehensive care plan is developed within seven (7) days of the completion of the resident's comprehensive assessment...</p> <p>Class III Based on observation, interview and record review the facility failed to ensure _____ are secure for two (Residents #7, and Resident #8) out of two residents reviewed for _____. As evidenced by _____ Resident #7's _____ was observed in the hallway carry his _____ bag in his _____ and at times placing it on the floor. Resident # 8 was observed with the _____'s drainage bag on his _____, and the tubing on the wheelchair's wheels. These deficient practices increases the risk for related urological _____ if the _____ is unintentionally pulled resulting in dislodgement.</p> <p>The findings include:</p> <p>Resident #7</p> <p>On _____ at 10:05 AM, Resident#7 was observed in the hallway with his _____ resting on his _____. At the time of the observation, there was no privacy bag in use to cover the _____. (Photographic evidence) On _____ at 11:28 AM, Resident#7's</p>	N 072		
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N 072	<p>Continued From page 5</p> <p>_____ was observed on the floor, the _____ was not properly secured or positioned. A staff member was noted performing 15-minute checks on residents, and did not notice the _____ bag on the floor (Photographic evidence)</p> <p>On _____ at 03:00 PM, Staff X, Licensed Practical Nurse (LPN), entered Resident #7's room. The nurse picked up the _____ bag and placed it on the side of the bed while the resident was sitting in the wheelchair; if the resident were to roll the wheelchair, there was a potential risk of the _____ being dislodged.</p> <p>Review of the medical records for Resident #7 revealed the resident was initially admitted to the facility on _____. Clinical diagnoses include but not limited to _____ of the _____ unspecified _____ obstruction, _____ prostatic hyperplasia without lower _____ tract symptoms and _____.</p> <p>Review of Resident#7's Physician's Orders for _____ included but not limited to _____ care every shift, _____ bag placed every morning; _____ to be changed monthly and as needed for occlusion or leakage, drainage bag to be changed once a day for _____ care ... output should be monitored every shift. Enhanced Barrier Precaution: Applied as necessary for control.</p> <p>Medication ordered include _____ 5 milligram (mg) 1 tablet by _____ daily for _____ Prostatic Hyperplasia (_____), _____ : 0.4 mg 1 capsule in the evening for _____.</p> <p>Record review of Resident #7 's Admission</p>	N 072			

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N 072	<p>Continued From page 6</p> <p>Minimum Data Set (MDS) dated _____ revealed: The resident has a brief interview mental status score of 00, indicating severe _____. Functionally, the resident has _____ upper extremity _____ but is independent in lower extremities, using a walker and wheelchair. The resident has an _____, is not on a toileting program, and is frequently _____. Active diagnoses include _____ insufficiency, _____, and other _____-related conditions.</p> <p>Record review of Resident #7 's Care Plans Reference date _____ and revised on _____ revealed: The resident has an _____ due to a _____, and the goal is to prevent _____-related _____. Interventions include positioning the _____ bag below the _____ and away from the door, checking for kinks in the tubing each shift, monitoring intake and output, and observing for signs of discomfort or _____. The resident has behavior issues related to noncompliance with the treatment regimen, including putting the _____ tube around the _____ and allowing the bag to drag on the floor, despite education and redirection. The goal for this behavior is to reduce episodes and avoid adverse consequences. Interventions include _____ the resident's needs, educating the family and caregivers on coping strategies, explaining procedures, discussing inappropriate behaviors, and intervening as needed to ensure the resident's safety and comfort.</p> <p>Interview on _____ at 02:56 PM, Staff X, LPN acknowledged that having the _____'s drainage bag on the floor was _____</p>	N 072		

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N 072	<p>Continued From page 7</p> <p>unacceptable due to the increased risk of and dislodgement.</p> <p>On at 3:06 PM, Staff T, Certified Nurse assistant and the Director of Nursing (DON) revealed they also made efforts to educate the resident about the risks of having the on the floor and explained that the resident was and did not consistently follow their instructions regarding care. During this interview Resident # 7 was observed ambulating unsteadily in the hallway holding the in his. Staff T assisted the resident to his room and placed the drainage bag on the wheelchair.</p> <p>Resident # 8</p> <p>On at 10:20 AM, Resident #8 was observed exiting the elevator with the drainage bag on his, and the tubing on the wheelchair's wheels increasing the risk for dislodgement and if the is unintentionally pulled out.</p> <p>On at 03:40 PM, Resident #8 was observed returning to his room after playing bingo, the bag and tubing were positioned in close proximity of the wheelchair's wheels increasing the risk for dislodgement of the. The DON was present and was shown the concerns; and revealed sometimes the resident move the around.</p> <p>Review of the medical records for Resident #8 revealed the resident was initially admitted to the facility on. Clinical diagnoses include but not limited to: of and and</p>	N 072		
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N 072	<p>Continued From page 8</p> <p>prostatic hyperplasia without lower tract symptoms.</p> <p>Review of Resident # 8's Physician's Orders Sheet for revealed orders that include, care is required every shift, to be changed monthly or as needed for occlusion or leakage. Medications included 5 mg daily for and 20 mg daily as a</p> <p>Record review of Resident #8 's Admission Minimum Data Set (MDS) dated revealed: The resident's brief interview mental status score is 13, indicating mild . The resident does not have in upper or lower extremities and uses a wheelchair. The resident has an and is not on a , or toileting program. Active diagnoses include and prostatic hyperplasia without lower tract symptoms.</p> <p>Record review of Resident #8 's Care Plans Reference date and revised on revealed focuses on managing the resident's due to and . The goals are to prevent -related and avoid . Key interventions include changing the as needed, positioning the bag properly, checking tubing for kinks, monitoring intake/output, and documenting symptoms of discomfort or resident sometimes lets the bag drag on the floor. The goal is to reduce these behaviors and prevent adverse consequences. Staff should monitor behavioral episodes and document potential causes to help manage future occurrences.</p>	N 072		

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N 201 N 201 SS=D	<p>Continued From page 9</p> <p>400.022(1)(l), FS Right to Adequate and Appropriate Health Care</p> <p>(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.</p> <p>This Statute or Rule is not met as evidenced by: Based on observation, interview and record review the facility failed to provide adequate and appropriate healthcare to prevent the potential risk of dislodgement for two (Residents #7, and Resident #8) out of two residents reviewed for . As evidenced by Resident #7's was observed in the hallway carrying his bag in his and at times placing it on the floor. Resident # 8 was observed with the 's drainage bag on his , and the tubing on the wheelchair's wheels. These deficient practices increases the risk for related urological if the is unintentionally pulled resulting in dislodgement.</p> <p>The findings include:</p> <p>Resident #7</p> <p>On at 10:05 AM, Resident#7 was observed in the hallway with his resting on his . At the time of the</p>	N 201 N 201	<p>Facility denies and disputes the validity of this citation and completes this POC solely to meet the requirements of State licensure and Federal regulations. Facility further denies any and all statements, acknowledgements, confirmations, or comments attributed to facility staff as strictly hearsay.</p> <p>1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>Resident #7 The drainage bag was properly placed on the frame of the bed by the Director of Nursing Resident #7 did not suffer any adverse effects r/t the , drainage bag being on the floor.</p> <p>Resident #8 Nursing staff to provide a</p>	
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N 201

Continued From page 10

observation, there was no privacy bag in use to cover the (Photographic evidence)
On at 11:28 AM, Resident#7's was observed on the floor, the was not properly secured or positioned. A staff member was noted performing 15-minute checks on residents, and did not notice the bag on the floor (Photographic evidence)

On at 03:00 PM, Staff X, Licensed Practical Nurse (LPN), entered Resident #7's room. The nurse picked up the bag and placed it on the side of the bed while the resident was sitting in the wheelchair; if the resident were to roll the wheelchair, there was a potential risk of the being dislodged.

Review of the medical records for Resident #7 revealed the resident was initially admitted to the facility on . Clinical diagnoses include but not limited to of the unspecified obstruction, prostatic hyperplasia without lower tract symptoms and

Review of Resident#7's Physician's Orders for included but not limited to care every shift, bag placed every morning; to be changed monthly and as needed for occlusion or leakage, drainage bag to be changed once a day for care ... output should be monitored every shift. Enhanced Barrier Precaution: Applied as necessary for control.

Medication ordered include 5 milligram (mg) 1 tablet by daily for Prostatic Hyperplasia (), : 0.4

N 201

bag when out of bed to mitigate risk of tubing getting caught in the wheelchair -wheel spokes and so the resident does not place the drainage bag on his as of

How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken;

Quality review by the DON/designee of current residents of residents with an to ensure are secure and the drainage bag is not on the floor and the drainage bag is covered, to be completed by

(3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur;

Current licensed nurses are re-educated by the DON/designee on the components of this regulation and to ensure are secure, the drainage bag is not on the floor and the drainage bag is covered to be completed by

(4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place;

DON /designee to conduct ongoing quality monitoring through visual observation of residents with an to ensure are secure, the drainage bag is not on the floor

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N 201	<p>Continued From page 11</p> <p>mg 1 capsule in the evening for</p> <p>Record review of Resident #7 's Admission Minimum Data Set (MDS) dated revealed: The resident has a brief interview mental status score of 00, indicating severe . Functionally, the resident has upper extremity but is independent in lower extremities, using a walker and wheelchair. The resident has an , is not on a toileting program, and is frequently . Active diagnoses include insufficiency, , and other -related conditions.</p> <p>Record review of Resident #7 's Care Plans Reference date and revised on revealed: The resident has an due to a , and the goal is to prevent -related . Interventions include positioning the bag below the and away from the door, checking for kinks in the tubing each shift, monitoring intake and output, and observing for signs of discomfort or . The resident has behavior issues related to noncompliance with the treatment regimen, including putting the tube around the and allowing the bag to drag on the floor, despite education and redirection. The goal for this behavior is to reduce episodes and avoid adverse consequences. Interventions include the resident's needs, educating the family and caregivers on coping strategies, explaining procedures, discussing inappropriate behaviors, and intervening as needed to ensure the resident's safety and comfort.</p>	N 201	<p>and the , drainage bag is covered 3 x weekly x 2 weeks, 2 x weekly x 2 weeks then weekly and PRN as indicated.</p> <p>The findings of these quality reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly x 2 months or until substantial compliance is met then quarterly ongoing. Schedule to be modified PRN based on findings.</p>		

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N 201	<p>Continued From page 12</p> <p>Interview on _____ at 02:56 PM, Staff X, LPN acknowledged that having the _____'s drainage bag on the floor was unacceptable due to the increased risk of _____ and dislodgement.</p> <p>On _____ at 3:06 PM, Staff T, Certified Nurse assistant and the Director of Nursing (DON) revealed they also made efforts to educate the resident about the risks of having the _____ on the floor and _____ explained that the resident was _____ and did not consistently follow their instructions regarding _____ care. During this interview Resident # 7 was observed ambulating unsteadily in the hallway holding the _____ in his _____. Staff T assisted the resident to his room and placed the _____'s drainage bag on the wheelchair.</p> <p>Resident # 8</p> <p>On _____ at 10:20 AM, Resident #8 was observed exiting the elevator with the _____ drainage bag on his _____, and the tubing on the wheelchair's wheels increasing the risk for dislodgement and _____ if the _____ is unintentionally pulled out.</p> <p>On _____ at 03:40 PM, Resident #8 was observed returning to his room after playing bingo, the _____ bag and tubing were positioned in close proximity of the wheelchair's wheels increasing the risk for dislodgement of the _____. The DON was present and _____ was shown the concerns; and revealed sometimes the resident move the _____ around.</p> <p>Review of the medical records for Resident #8</p>	N 201		
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Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 111353	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/27/2025
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NAME OF PROVIDER OR SUPPLIER GARDENS NURSING AND REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 190 NE 191ST STREET MIAMI, FL 33161
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N 201	<p>Continued From page 13</p> <p>revealed the resident was initially admitted to the facility on . Clinical diagnoses include but not limited to: of of and and prostatic hyperplasia without lower tract symptoms.</p> <p>Review of Resident # 8's Physician's Orders Sheet for revealed orders that include, care is required every shift, to be changed monthly or as needed for occlusion or leakage. Medications included 5 mg daily for and 20 mg daily as a</p> <p>Record review of Resident #8 's Admission Minimum Data Set (MDS) dated revealed: The resident's brief interview mental status score is 13, indicating mild . The resident does not have in upper or lower extremities and uses a wheelchair. The resident has an and is not on a , or toileting program. Active diagnoses include and prostatic hyperplasia without lower tract symptoms.</p> <p>Record review of Resident #8 's Care Plans Reference date and revised on revealed focuses on managing the resident's due to and . The goals are to prevent -related and avoid . Key interventions include changing the as needed, positioning the bag properly, checking tubing for kinks, monitoring intake/output, and documenting symptoms of discomfort or ...resident sometimes lets the bag drag on the floor. The goal is to reduce these behaviors and prevent</p>	N 201		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 111353	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/27/2025
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N 201	Continued From page 14 adverse consequences. Staff should monitor behavioral episodes and document potential causes to help manage future occurrences. Class III	N 201		