PRINTED: 11/30/2021 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_\_ P.C B MING 111356 11/02/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9869 SW 152ND STREET CORAL REEF SUBACUTE CARE CENTER LLC MIAMI, FL 33157 (X433F) SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (N 000) INITIAL COMMENTS (000 N3 An unannounced complaint survey for complaint numbers 2021013844 and 2021013886,was , through , at Coral Reef Subacute Care Center. The allegations for complaint number 2021013844 was substantiated without deficient practice and the allegations for complaint number 2021013886 was substantiated with deficient practice. Deficiencies were identified at Class I at the time of the survey. Class I deficiencies are those which the agency determines present an imminent danger to the residents of the facility or a substantial probability that .... or serious physical harm would result there from. The Class I deficiencies were identified at: N 204 - Scope and Severity (J) - Freedom from and Neglect N 201 - Scope and Severity (J) adequate and appropriate healthcare N 216 - Scope and Severity (J) Health and safety of Residents The facility's Administrator, Director of Nursing and Regional Nurse Consultant were notified of the Class I deficiencies on . . . . , at 5:54 PM

SS=J Appropriate Health Care

132

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

The following is a description of the non-compliance:

(N 201) 400.022(1)(I), FS Right to Adequate and

The facility census at the time of the survey was

TITLE (X6) DATE Electronically Signed /21

(N 201)

STATE FORM If continuation sheet 1 of 35 ET8W12

PRINTED: 11/30/2021 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: P.C B MING 111356 11/02/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9869 SW 152ND STREET CORAL REEF SUBACUTE CARE CENTER LLC MIAMI, FL 33157 (X433ID) SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) {N 201} Continued From page 1 (N 201) (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 theraneutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency. This Statute or Rule is not met as evidenced by: Based on interview and records reviewed, the facility failed to ensure a resident's mental health care needs was adequately supervised by a psychiatrist for one (Resident #1) out of ten residents sampled as evidenced by facility failure to effectively monitor behaviors and report said behaviors related to Resident #1's diagnoses of and and episodes of afraid/panic to the psychiatrist. The facility failure led to Resident #1 while unsupervised in his room inflicted self-harm and suffocated himself by placing a trash bag over his , resulting in .... by ..... as a result of the deficient practice. There were 17 residents receiving ..., medications and 47 residents

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receiving

the facility at the time of this survey. The Findings Included:

and procedures titled. general statement noted: medications include any drug that affects activities associated with meant process and

behavior, including

Record review of the facility's undated policies

. , . , and . . . . . classes of drugs. Physicians and physician -extenders (Ex.

medications residing in

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Procedures followed by the Primary Care Physician, PA [Physician's Assistant], or NP [Nurse Practitioner] Noted: 2. Documents rationale and diagnosis of the use and identifies target symptoms. 4. Evaluates with the interdisciplinary team, effects, and side effects of .... medications within 14 days of initiating, increasing, or decreasing dose and during routine visits thereafter.

utilized to meet the needs of individual resident. G. Psychopharmacological medications will be used to enhance the quality of life for the resident and will never be used for the purpose of discipline or convenience.

Procedures Followed by the Psychiatrist / mental , assist the facility in health included: 1. establishing appropriate guidelines for use, dosage and monitoring of . . . medications. 5. Helps develop behavior management plans.

Procedures Followed by Nursing: 1. Monitors ..., drug use daily, noting any adverse effects such as increased somnolence or functional decline

2. Will monitor for the presence of target behaviors on a daily basis. Behaviors will be documented as warranted.

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behavior such as

episode noted "Routine."

changes or danger to

self. There was no behavior record to indicate that he was monitored for his diagnosis of and for the use of Further review of the behavior monitoring sheets showed that Resident #1 had multiple episodes documented as "Afraid/Panic". The behavior monitoring sheet initiated on ..... indicated Resident #1 had a total of 9 episodes of Afraid/Panic. Five out of nine different episodes occurred during the hours of 7:00 AM to 7:00 PM on . . , . . , 17, 20, and 25. Four different episodes of Afraid/Panic occurred between the hours of 7:00 PM to 7:00 AM, on ..., ..., 27 and 28. The documented interventions for each

Review of the nurses' progress notes for the

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER'SUPPLIENCLIA
IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A BUILDING:

R-C

111356

8. WING

1110/2/2021

.....

NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE			
CORAL REEF SUBACUTE CARE CENTER LLC		9869 SW 15 MIAMI, FL	33157		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FL REGULATORY OR LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
(N 201)	Continued From page 4 month of , showed no record that addressed any of the episodes of exhibited by Resident #1.  Review of the behavior sheets for documented an initiated date of	It (left a day left a	(N 201)		

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PRINTED: 11/30/2021 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_\_ P.C B MING 111356 11/02/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9869 SW 152ND STREET CORAL REEF SUBACUTE CARE CENTER LLC MIAMI, FL 33157 (X433ID) SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (N 201) Continued From page 5 (N 201) Review of the behavior monitoring sheet dated ....., showed that Resident#1 had a total of three Afraid/Panic episodes. Resident #1 had one episode of Afraid/Panic between 7:00 PM to 7:00 AM on #1 had two episodes of the Afraid/Panic that occurred during the day shift (7:00 AM to 7:00 PM) on . . . . and on the day of his . . . , . Interventions for each episode noted "Routine QHS." Review of the progress notes for , showed no recorded documentation that addressed any of the episodes exhibited by Resident #1. On at 12:15 PM, during an interview and record review with the Director of Nursing (DON), and the Clinical Regional Nurse. The DON explained: the nurses on the floor usually complete the behavior monitoring sheets. The nurses are the ones that monitor and document the behaviors. the CNA would report each behavior to the nurses. Behaviors that are reported and documented are behaviors that are unusual for the patient and any behavior that might put the patient in distress, such as

needed.

The clinical records were discussed related to the Plan of care the DON explained diagnoses of ..., ..., depends on the patient. For just about anybody, the care planned interventions include provide emotional support. Activities, whatever they are interested in encouraging them to talk about their feelings. Encourage socialization, provide feedback to reinforce positive behaviors. Notify MD of changes as

Review of the investigative report and interview with the Clinical Regional Nurse on approximately 2:30 PM revealed, the Clinical

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FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R-C 111356 B. WING \_\_ 11/02/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

9869 SW 152ND STREET

CORAL R	FEF SUBACUTE CARE CENTER LLC	W 152ND STREET FL 33157		
(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 DEFIGIENCY)	(X5) COMPLETE DATE
{N 201}	Continued From page 6 regional nurse had reviewed the facility's video recording as she investigated the event. The Clinical Regional Nurse documented her observation of the video and reported that she reviewed the video recording on "Tuesday or Thursday last week." The report noted that on Saturday at 2:54 PM Resident #1's CNA, (Staff A) went into the residents' room [room #] at 4:18 PM. Nurse [Staff B] was passing meds. The Clinical Regional Nurse stated: "You can see the regioning and out of rooms." At 4:30 PM the friend [Resident #4] leaves Resident #1's room. The video showed that at 4:52 PM meal was	(N 201)		
	delivered to Resident #1's room. His door remained open the whole time. At 5:21 PM the Nurse [Staff B] went into Resident #1's room. At 5:43 PM the CNA [Staff A] picked up the tray, (Noted that he at 100%). At 6:25 PM it appears the door is shut from inside the room. No one checked on the resident or attempted to enter the room from approximately 6:25 PM to 8:15 PM [Staff C], LPN was scheduled to start her shift at 7:00 PM, no indication that she checked on Resident #1 from time her shift started until the CNA called her at around 8:15 PM. At 8:15 PM, the CNA tried to get into the room and noted that the door was closed. The CNA tried to open the door, but it was blocked. Staff Awas in the room for a few second, leaves the area, gets the nurse and the crash cart. The Regional nurse			
	explained that The CNA had to push the door opened and when he entered, the room he noted Resident #1 seated in his wheelchair, unresponsive with a bag over his . The CNA stated that he pulled the bag off Resident #1's and ran to get help. A code was called as well as 911, staff responded to this resident's room where they transferred him to the bed, a backboard was placed, and . initiated. Law enforcement and EMTs [Emergency Medical			NATIONAL PROPERTY OF THE PROPE

11/02/2021

Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R-C

B. WING \_\_\_\_\_

111356

NAME OF PI	ROVIDER OR SUPPLIER STREE	T ADDRESS, CITY, STATE	E, ZIP CODE	
CORAL R	FEE SUBACUTE CARE CENTER LLC	SW 152ND STREET I, FL 33157		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 201}	Continued From page 7	{N 201}		
	Technician] responded shortly thereafter and pronounced this Resident, The Residents body was transferred to the Medical Examiner's office.			No. of the Contract of the Con
	On			
	days that I worked. I filled it out on, the day that he What I documented was that he had one behavior of Staff B, RN explained that Resident #1 kept asking about the			
	( ) treatment. The intervention, during the , episode was teaching about the reason for the treatment, what was the reason, and why he remained in isolation. Staff B stated that her documentation on the behavior monitoring sheets about the afraid/panic episode was related to the treatment, that Resident #1 received the treatment and that it was effective. Staff B stated: "I did not document."			

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Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R-C B. WING \_\_\_\_\_ 111356 11/02/2021

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
CORAL R	CORAL REEF SUBACUTE CARE CENTER LLC 9869 SW 152ND STREET MIAMI, FL 33157					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE		
{N 201}	Continued From page 8 in the nurses notes that the resident was having episode of , because I did my action, I did not see him to be desperate, he allowed me to administer his treatment." Staff B reported that the purpose of the behavior monitoring sheet is	{N 201}				
	to follow for a prescribed medication, and document the episodes related to the behavior, for which the resident is taking the medication. The intervention was to refer to nurses notes. Staff B agreed there was no record to explain anything about the resident's or behavior. Staff B stated: "It's					
	established that a patient can have at least three small episodes of, we take action if they have a big one. Big ones we would document on the nurses' notes. The purpose of the behavior monitoring sheet is to see if the medication seems effective throughout the monthwhat the					
	behavior monitoring sheet shows is that the medication is effective. I documented that he had on on some shows the behavior of the shower of t					
	not reflect the exact nature, or details of the behavior, she did not know and could not recall the behavior. Staff B stated: I also documented no behavior on 10th, 11th, 16th, 17th, 24th, 25th, 26th. When I noticed the					
	behavior, I did not report to anyone. I did not think that I needed to communicate it to the psychiatrist. We did not monitor him for I did not know he had any or diagnoses of With					
	a diagnosis of "Staff B explained that she would have reacted differently and that					

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message was left. On

behavior exhibited by Resident#1 to him. "If they tell me I would definitely do something. The nurses usually call me. They did not tell me about those episodes. Had I known, I would have definitely done something, I would have gone to see him, maybe change the medication at 12:13 PM attempted to interview Staff C, LPN by phone and a voicemail

Staff C was called again and Staff C answered

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at 5:04 PM

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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:		COMPLETED
	111356	B. WING	R-C 11/02/2021

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NAME OF P	ROVIDER OR SUPPLIER	STREET ADDRES	S, CITY, STAT	E, ZIP CODE	1
CORAL R	EEF SUBACUTE CARE CENTER LLC	9869 SW 152N MIAMI, FL 331			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
(N 201)	Continued From page 10  the phone and requested for the surveyor to in 15 minutes. On 5:24 PM C was called, Staff C was asked if Residenthad any complaints of while under her of Staff C responded, "nol never, he never had complaints." When asked to clarify her note that the resident had the call was disconnected. On the call was for your propers of your while under care. Staff C reported, "no!" Staff C was as to clarify the police because he was complaining of so much. "Staff C was as to clarify the documentation because the not indicated that the resident had called the polic Staff C, I.PN then explained that the police we called to help Resident #1 calm down while is helped him transfer to the hospital.	call staff #1 #1 staff #1 #1 staff #1 #1 staff #1 #1 staff #1 staff staf	J 201}		
(N 204) SS=J	400.022(1)(o), FS Right to be Free from, etc  (o) The right to be free from mental and , , corporal punishment, extended involuntary, and from physical and chemical except those authorized in writing by a physician for a spe authorized in writing by a physician for a spe and limited period of time or as are necessite by an emergency. In case of an emergency, may be applied only by a qualified licensed nurse who shall set forth in writing the control of the co	cified ated	1 204}		

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or nealect ..."

property...Neglect is defined as failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Preventive measures included: The assessment. care planning, and monitoring of residents with needs and behavior which might lead to conflict

Record review of the facility's policies and procedures revealed the {undated} policy Name: ..... Medication. The General Statement of Policy noted; , medications include

11/02/2021

Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R-C

NAME OF PROVIDER OR SUPPLIER

B. WING \_\_\_\_ STREET ADDRESS, CITY, STATE, ZIP CODE

111356

CORAL RI	EEF SUBACUTE CARE CENTER LLC 9869 SW MIAMI, F	152ND STREET L 33157		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 204}	Continued From page 12	{N 204}		
	any drug that affects activities associated with process and behavior, including dasses of drugs. Physicians and physician-extenders (Ex. Physician Assistant, Nurse Practitioner) will use, medications appropriately, working with the interdisciplinary team rurse to ensure appropriate use, evaluation, and monitoring. Standards included:  C. The facility supports the goal of determining the underlying cause of behavioral symptoms so the appropriate treatment of environmental, medical and /or behavioral interventions, as well as psychopharmacological medications can be utilized to meet the needs of individual resident.  G. Psychopharmacological medications will be used to enhance the quality of life for the resident and will never be used for the purpose of discipline or convenience.			
	Procedures followed by the Primary Care Physician, PA[Physician's Assistant], or NP [Nurse Practitioner] noted: 2. Documents rationale and diagnosis of the use and identifies target symptoms. 4. Evaluates with the interdisciplinary team, effects, and side effects of medications within 14 days of initiating, increasing, or decreasing dose and during routine visits thereafter. Procedures Followed by the Psychiatrist / mental health included: item 1 indicated- assist the facility in establishing appropriate guidelines for use, dosage and monitoring of, medications. Item number 5 indicated- Help develop behavior management plans.  Procedures Followed by Nursing:  1. Monitors, drug use daily, noting any adverse effects such as increased			
-ICA Form 30	somnolence or functional decline.			

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STATE FORM 0.000 ET8W12 If continuation sheet 13 of 35 Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R-C 111356 B. WING \_\_\_\_ 11/02/2021

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

CORAL R	EEF SUBACUTE CARE CENTER LLC 9869 SW 15	32ND STREET 33157		
(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 DEFIGIENCY)	(XS) COMPLETE DATE
(N 204)	Continued From page 13  2. Will monitor for the presence of target behaviors on a daily basis. Behaviors will be documented as warranted.  3. Reviews the use of the medication with the physician and the interdisciplinary team on a quarterly basis to determine the continued presence of target behavior and or the presence of any adverse effects of the medication use.  4. [	(N 204)	DEFINITION	
	Record review of the Comprehensive Minimum			

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P.C

11/02/2021

Agency for Health Care Administration
STRTEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIERCUA IDENTIFICATION NUMBER: A BUILDING: COMPRETED C

111356 B. WING \_\_\_\_\_

## NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9869 SW 152ND STREET CORAL REEF SUBACUTE CARE CENTER LLC MIAMI, FL 33157 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) {N 204} Continued From page 14 (N 204) Data Set (MDS) and interview with the MDS coordinator, Staff H on AM revealed, Resident #1 was Re-admitted to the facility on . In his most recent comprehensive MDS, dated . . . . . . He had a score of 15 on the ..... ( ), which indicated that the resident was able to verbalize his needs and was not , .... Further review of the MDS revealed that Resident #1 had a clear speech pattern and was able to understand others as well as make self-understood. His active diagnoses included . . , . . . . . (. ), . . . , but the MDS did not include the diagnosis of ..... Review of the care plans for Resident #1 revealed a care plan dated : "Resident #1 exhibited behaviors of . ...,/agitation. Goals: Resident #1 will be able to display appropriate response to situations by next review date." Approaches included, Determine cause of .... Observe for changes in mental status. and behavior, Notify MD [Medical Doctor] of changes as needed. Further review of the care plans showed that Resident #1 had diagnoses of and was at risk for alterations in pattern. Approaches included, observe for changes in ..., encourage verbalization of feelings, administer There were no care plans for the diagnoses of , or for the use of 5 ma tablet Record review of Resident #1's Rehavior Monitoring Sheets for the months of ,, ..., ... and ..... , indicated that Resident # 1 was monitored for the behaviors afraid/panic. Related to the use of \_\_\_\_\_1

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mg 1 tablet. There was no record to indicate

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Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R-C B. WING 111356 11/02/2021

NAME OF PI	ROVIDER OR SUPPLIER	STREET ADDR	ESS, CITY, STA	TE, ZIP CODE	
CORAL R	FEF SUBACUTE CARE CENTER LLC	9869 SW 152 MIAMI, FL 3	ND STREET 3157		
(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
	REGULATORY OR LSC IDENTIFYING INFORMATION  Continued From page 15  that Resident #1 was monitored for any other behavior such as changes or danger to self.  Review of Resident #1's behavior monitoring records showed no records to indicate that he was monitored for his diagnosis of	or so the state of		CROSS-REFERENCED TO THE APPROPRIATE	
ii' A Form 3	Record Review of the Nurses Progress Notes from to showed no recorded documentation that addressed any of the episodes of exhibited by Resident Review of behavior monitoring sheet for (Initiated on ) showed no record and was left blank for an and during the day shift (7:00 AM to 7:00 PM). The behavior sheet for Indicate documented behavior "Afraid/Panic" was not monitored during that time. Further review of behavior monitoring records for revealed Resident #1 had 15 different episode Afraid/Panic during the evening shift (7:00 PM).	of #1.			

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Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R-C

NAME OF PROVIDER OR SUPPLIED

B. WING

111356

NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
CORAL REEF SUBACUTE CARE CENTER LLC		9869 SW 152ND STREET				
OUTAL III	EL BODAGO L'OANE GENTEN ELG	MIAMI, FL 33157				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY F REGULATORY OR LSC IDENTIFYING INFORMAT	ULL PREF	(EACH	OVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{N 204}	Continued From page 16	{N 204}				
(N 204)	7:00 AM). The Afraid/Panic behaviors occus on 9,10,11,13, 15, 16,17,18,19, 22 4,25 and 22. Review of Nurses Progress Notes for showed no record that addressed any episodes of afraid/panic exhibited by Reside Review of behavior monitoring sheets for for Resident #1 showed the resident continued to be monitored for episod Afraid / Panic. Resident #1 had a total of different episodes during the month of Four out 17 different episodes Afraid/Panic occurred between 7:00 AM to PM: on ,3,4, and 5. The interven order Routine CHS (every night at bedtime indicating that the facility's only intervention the administration of his routine medication; and administration of his routine medication the daministration of his routine medication of 17 different episodes of Afraid/Panic occurred on ,7, 12, 13, 14, 17, 20, 21, 24, 26, 27 and 28. The intervention of Refer to Nurses Notes. Treit revord to showed no record that addressed any of the episodes of afraid/pare shibited by Resident #1.	rered 2, 23,  of the ent #1.  of the ent #1.  of o				
	Review of the behavior monitoring sheet for showed that Resident#1 had total of three episodes of Afraid/Panic. Two episodes of Afraid/Panic occurred during the shift (7:00 AM to 7:00 PM) on a the shift of the shi	la e day and on at #1			to and a state of the state of	

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PRINTED: 11/30/2021 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: P.C B MING 111356 11/02/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9869 SW 152ND STREET CORAL REEF SUBACUTE CARE CENTER LLC MIAMI, FL 33157 (X433ID) SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) {N 204} Continued From page 17 (N 204) interventions for each episode noted "Routine QHS." indicating that the facility's only intervention was the administration of his routine medication: 1 mg tablet by ... at hedtime. Review of the progress notes for showed no record that addressed the afraid/panic episodes exhibited by Resident #1. Further review the nurses progress notes dated with time noted as 11:00 PM documented by LPN, Staff C revealed: "Resident assigned CNA [Certified Nursing Assistant] was observed running over to me while I was doing my med pass as he verbalized code blue. I immediately assigned a staff member to call 911 as I grabbed the defibrillator machine. I assigned another staff member to get the crash cart. I ran

[ . . . . . ] was initiated. 911 arrived and EMT/Emergency Medical Technicians] pronounced his . . . . No obvious injuries were noted at the time of assigned to this resident verbalized that he was unable to enter his room. The CNA stated he had to push very hard to open the door. CNA stated resident wheelchair was pushed against the door with patient sitting in the wheelchair. Trash bag was noted over his . CNA stated he removed the trash bag to see if patient was not breathing. Patient was not breathing per CNA statement. CNA then verbalized to me and to the police how he found the patient. Family was notified by police. Police officer spoke to [Emergency Contactl. The medical examiner arrived and

to his room. The residents skin color was noted color, no

was transferred from wheelchair to the bed. board was placed under the patient and

was noted resident

PRINTED: 11/30/2021 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_\_ P.C B MING 111356 11/02/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9869 SW 152ND STREET CORAL REEF SUBACUTE CARE CENTER LLC MIAMI, FL 33157 (X433F) SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (N 204) Continued From page 18 (N 204) transferred residents' body out of the facility." Review of the investigative report and interview with the Clinical Regional Nurse on approximately 2:30 PM revealed, the regional nurse reviewed the facility's video recording as she investigated the event. She documented her observations of the video. The Clinical Regional Nurse reported that she reviewed the video recording on "Tuesday or Thursday last week." The investigative report noted that on Saturday at 2:54 PM Resident #1's Certified Nursing Assistant (CNA) (Staff A) went into the residents' room [room #] at 4:18 PM. Nurse (Staff B), Registered Nurse (RN)was passing meds, "you can see her going in and out of rooms." At 4:30 PM the friend (Resident #4) leaves Resident #1's room. The video showed that at 4:52 PM meal was delivered to Resident #1's room. His Door remained open the whole time. At 5:21 PM the Nurse (Staff B) went into Resident #1's room. At 5:43 PM the CNA [Staff A] picked up the tray. Noted that he ate 100%. At 6:25 PM it appears the door is shut from inside the room. No one checked on the resident or attempted to enter the room from approximately 6:25 PM to 8:15 PM (Staff C, LPN) was scheduled to start her shift at 7:00 PM. no indication that she checked on Resident #1 until the CNA called her at around

8:15 PM. At 8:15 PM. the CNA tried to get into the room and noted that the door was closed. The CNA tried to open the door, but it was blocked. (Staff A.) was in the room for a few second. leaves the area gets the nurse and the crash cart... The Regional nurse explained that the CNA had to push the door open and when he entered. he noted Resident #1 seated in his wheelchair. unresponsive with a bag over his

stated that he pulled the bag off Resident #1

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The CNA

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AM -3:00 PM and from 3:00 PM to 11:30 PM. He continued on Saturday to again work from 7:30 AM to 11:30 PM. Staff A explained. "on from my break which is from 8:00 PM to 8:30 PM, when I came ... and was doing my rounds and noticed that the door would not open. I spoke to one of the CNAs. He recommended; I pushed the door. I thought he might have blocked the door with something. When I finally opened the door, I noticed the resident was sitting in his chair with a plastic bag over his ..... The wheelchair was locked. He normally had two trash containers, one on each side of his bed, with plastic bag inside of it. Once I opened the

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NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE			
CORAL REEF SUBACUTE CARE CENTER LLC		9869 SW 15 MIAMI, FL	2ND STREET 33157		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FL REGULATORY OR LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
(N 204)	Continued From page 20 door, I notice the plastic bag on his It the plastic bag; I threw it on the floor and or for help. The floor nurse was on the hallway went to get the crash cart. She called code The nurse and I transferred the resident fron wheelchair, they initiated the They all continued until the ambulance arrived. The p arrived they interviewed me. I could not lea the facility until after the detective interviewe me." Staff A, CNA explained that sometimes Resident #1 was aggressive and had behav like refusing care such as he refused a hairc and refused to shave and Staff A convinced Resident #1 and allowed Staff A to shave he Staff A added "not that long ago, maybe two weeks", (Resident #1) until sometimes get and yell at staff; "like one time, he took of h gown and threw at me, I told the nurse on the floor about the behavior and asked her to co to the room and help me translate. I explainin [Resident #1] that I was here to take care of and that there was no need to be aggressive toward me, [Resident#1] understood and exapologized."	ied We bblue. In the  police vive d d s s iors  cut angry isis ne mme d d to him, be	{N 204}		
	On at 12:15 PM, during an intenwith the Director of Nursing (DON) and the Clinical Regional Nurse, the DON explained nurses on the floor usually complete the bel monitoring sheets. The nurses are the ones monitor and document the behaviors, the C would report each behavior to the nurses. Behaviors that are reported and documente behaviors that are sunusual for the patient an behavior that might put the patient in distress such as The plan of care for diagnor of depends on the patient. For ju about anybody, the care planned interventio include provide emotional support for all staff.	; The havior that NA d are d any s, sees ust			

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11/02/2021

Agency for Health Care Administration
STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION
STATEMENT OF DEFICIENCIES
IDENTIFICATION NUMBER:
(C2) MULTIPLE CONSTRUCTION
A BUILDING:

R\*C

NAME OF PROVIDER OR SUPPLIER

111356

CORAL REEF SUBACUTE CARE CENTER LLC 9869 SW 152ND STREET MIAMI, FL 33157				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
(N 204)	Continued From page 21	{N 204}		A. Carrier
	activities, it is whatever the residents are interested in. Encourage them to talk about their feelings. Encourage stoeliation. Provide feedback to reinforce positive behaviors. Notify MD ( Medical Doctor) of changes as needed. Psych consult as needed and Administer as ordered. During the interview, record review of Resident #1's clinical record showed, Resident #1's for leading record showed, Resident #1's for larging size of the strength of			

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PRINTED: 11/30/2021 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: P.C B MING 111356 11/02/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9869 SW 152ND STREET CORAL REEF SUBACUTE CARE CENTER LLC MIAMI, FL 33157 (X433ID) SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) {N 204} Continued From page 22 (N 204) . . , it shows that we monitor for behaviors "Fear/Panic, , kind of stuff." According to the nurse's documentation on the Behavior Monitoring Sheets Resident #1 had panic/ episodes," The DON explained: "The nurses and general staff reported that the resident was showing frustration over his health. He did not like . He did talk about it sometimes. He had ...., on ..... and 2nd. The only intervention was the medication as documented on the Behavior Monitoring Sheets ... We do not have a behavior monitoring record for the use of Regional Nurse both agreed to review the residents record for any notes that addressed Resident #1's behaviors, and acknowledged there were no actual written notes that addressed any of the resident's behaviors or DON and the Clinical Nurse Manager agreed such documentation was necessary.

the Psychiatrist explained that Resident #1 gave no indication that he was depressed, and that the facility staff was "usually very good at letting us know when there is any indication, not only present, but also past history, or any indication of . They usually call me for an clinical , evaluation. I see most of the patients that are , they usually generate a consult for me. If the patient had shown any signs or symptoms, indicating they had clinical or the staff would

at 12:05 PM, during an interview

have notified me." The Psychiatrist acknowledged that he saw Resident #1 once, on ..... and that his diagnoses included and ..... A continued interview with the Psychiatrist on at 10:56 AM revealed

the psychiatrist did not review the above-mentioned Behavior Monitoring Sheets

Agency for Health Care Adminis	tration		FORWIAFFROVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	111356	B. WING	R-C 11/02/2021

NAME OF P	ROVIDER OR SUPPLIER STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
CORAL REEF SUBACUTE CARE CENTER LLC 9869 SW 152ND STREET MIAMI, FL 33157					
(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	
PREFIX	SUMMAY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MISS TO PRECEDED BY THUL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 23  found in Resident #1's clinical record. The Psychiatrist explained that he met with facility staff and discussed residents behaviors and if any adjustments are needed. The Psychiatrist was asked about Resident #1's behaviors. The Psychiatrist reported he was not aware that Resident #1 had any behaviors. Upon discussion of multiple documented episedes of afraid/panic noted on Resident #1's clinical records the psychiatrist reported he was not aware of any of the documented behaviors and stated that the nurses did not communicate said behaviors to him. The psychiatrist stated that the facility staff should have communicated any arriad/panic episodes and other behavior exhibited by Resident #1 to him. If they tell me I would definitely do something. The nurses usually call me. They did not tell me about those episodes. Had I known, I would have definitely done something, would have gone to see him, maybe change the medication.*  On 12:51 PM, review of Social Services assessment dated and interview with the facility's Social Services Staff; Social Services Director (SSD) and Social Services Assistant (SSA), Staff F, it was revealed that social services is responsible for assessing the residents upon admission, quarterly, and	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETE	
	annually. The SSD revealed social services saw the residents often around the facility, assess for (Brief Interview of Mental Status) score, moods, and behaviors. The SSD stated he went to the resident's room to complete the initial assessment on Review of the social services note dated indicated social services will be available to Resident #1 and family for support if needed The and assessment indicated the resident had little interest or pleasure in doing things.				

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them." Interview on

the facility since

learned about residents concerning behaviors during morning meetings and never knew that he had any behaviors. When asked why there was only one social services assessment and progress note in Resident #1's clinical record, the SSD responded. "There must have been other progress notes. I don't know what happened to

Staff B Registered Nurse(RN) reported working in

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, at 10:01 AM with

, this year and normally

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES (X1) PROVIDERSUPPLIENCLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED

A BUILDING:

111356

B. WING

1100/22021

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

CORAL R	EEF SUBACUTE CARE CENTER LLC 9869 SW MIAMI, F	152ND STREET L 33157		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
(N 204)	Continued From page 25 worked with (Resident #1) three days a week, from 7:00 AM to 7:00 PM. The resident was alert and oriented times three. He communicated his needs well. He normally slept until about 9:00 AM/10:00 AM. He liked to participate in, and activities. He liked to orone out of the rom. On the day of the incident (Resident #1) was on isolation precautions due to a ( ) .) Staff B, RN stated, "I worked from Thursday, , to Saturday . I monitored for behaviors related to his use of , we monitored for sensitive states of , we monitored for fore with the consection of the state of , we monitored for sensitive states of , we monitored for Generally, I don't remember him having any behavior. He sometimes would get a little upset with the CNAs, asked that we closed the door, close the window, or yell, don't touch mel Generally, I document if the patient's behavior is constant. Normally, he was easily re-directed." Staff B, RN reported not being present when Resident #1 had the aggressive behavior of throwing his gown at Staff A, CNA. "I did complete the behavior monitoring sheet for the resident on the days that I worked. I filled it out on  and  , the day that he  , what I document was that he had one behavior of Staff B, RN explained, "he was asking a lot about why he remained with the treatment, about the  ( ), He kept asking about it, although I had already spoken to him about it. The intervention, during the  , geisode was teaching about the reason for the treatment, what was the reason, and why he remained in isolation. What I documented on the behavior monitoring sheets about afraid/panic episode was related to the  resident was having an episode of	{N 204}	DEFICIENCY	
	because I did my action, I did not see him to be			

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PRINTED: 11/30/2021 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_\_ P.C B MING 111356 11/02/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9869 SW 152ND STREET CORAL REEF SUBACUTE CARE CENTER LLC MIAMI, FL 33157 (X433F) SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) {N 204} Continued From page 26 (N 204) desperate, he allowed me to administer his treatment. Sometimes with the elderly, they usually ask a lot about their treatment. The episode of . , noted on him, was normal, expected. The purpose of the Behavior Monitoring Sheet is to follow for a prescribed ... medication, and document the episodes related to the behavior, for which the resident is taking the medication. The intervention was 12 - Refer to nurses' notes." Staff B upon review of the records agreed there was no record to explain anything about the resident's behavior. Staff B stated that: " It's established that a patient can have at least three small episodes , we take action if they have a big one. Big ones we would document on the nurses' notes. The purpose of the behavior monitoring sheet is to see if the medication seems effective throughout the month. What the behavior monitoring sheet shows is that the medication is effective. I documented that he had . . . . on , 3rd, and 4th. The one episode could have been something like, "I don't want to shower. I don't know the behavior." Staff B

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agreed that the documentation does not reflect the exact nature, or details of the behavior, she did not know, could not recall. Staff B added, " I also documented no behavior on 10th, 11th, 16th, 17th, 24th, 25th, 26th. When I noticed the behavior. I did not report to anyone. I did not think that I needed to communicate it to the Psychiatrist. We did not monitor him for .... I did not know he had any or diagnoses of

B then explained that with a diagnosis of she would react differently because ..... are very dangerous, levels of

in a person's cause them to have a crisis. " On that day he seemed well. he did not seem depressed, he did

." Staff

can change and

PRINTED: 11/30/2021 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: P.C B MING 111356 11/02/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9869 SW 152ND STREET CORAL REEF SUBACUTE CARE CENTER LLC MIAMI, FL 33157 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) {N 204} Continued From page 27 (N 204) not reject care, or complain of ..... " Upon discussion of Resident #1's Diagnoses, Staff B, RN reported. "I am surprised that he had a . "When I left on that day he remained in his bed. I went in to see him at approximately 7:10 PM he was in his room, he asked we close the door." Interview with Regional Nurse and discussion of surveillance video showed that staff B last saw the resident at approximately 5:21 PM.

Staff C was asked whether or not the resident ever expressed or showed any signs or symptoms of or or while under her care, Staff C again reported, "no", when asked about her handwritten nurses' notes dated 12:00PM Staff C, stated: "oh yeah.

Record review revealed Resident #1 was under the care of Staff C Licensed Practical Nurse (LPN) one of the two times it was documented that Resident #1 called the police because he

) and on the night

attempted to conduct a telephone

was in so much . (

telephone interview on

interview with Staff C, LPN on at 12:13 PM and a voice message was left. On at 5:04 PM telephone call was made

STATE FORM 6990 ET8W12 H continuation sheet 28 of 35

PRINTED: 11/30/2021 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_\_ P.C B MING 111356 11/02/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9869 SW 152ND STREET CORAL REEF SUBACUTE CARE CENTER LLC MIAMI, FL 33157 (X433F) SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) {N 204} Continued From page 28 (N 204) one time, I had to call the police because he was complaining of so much . Staff C was asked to clarify if she had called the police or if Resident #1 had called the police, staff C stated that Resident #1 was the one who called the police. Staff C stated: "He did call the police!" Staff C LPN explained: the police was called to help Resident #1 calm down while she helped him transfer to the hospital. Class I (N 216) 400.102(1), FS Health and Safety of Resident (N 216) SS=J In addition to the grounds listed in part II of chapter 408, any of the following conditions shall be grounds for action by the agency against a licensee: (1) An intentional or negligent act materially affecting the health or safety of residents of the facility; This Statute or Rule, is not met as evidenced by: Based on records reviewed and interviews, the facility failed to ensure adequate behavior monitoring and supervision was provided for one resident (Resident #1) out of 10 sampled residents of the 17 Residents that received , medications and 47 residents that received . . . , . . . medications. The facility failed to effectively monitor behaviors related to

Resident #1's diagnoses of and multiple episodes of panic and afraid which lead to Resident #1 self-inflicted harm. Resident #1 while unsupervised in his room, placed a plastic trash bag over his ... and suffocated

bv

himself resulting in

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PRINTED: 11/30/2021 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_\_ P.C B MING 111356 11/02/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9869 SW 152ND STREET CORAL REEF SUBACUTE CARE CENTER LLC MIAMI, FL 33157 (X433F) SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) {N 216} Continued From page 29 (N 216) The Findings Included: Record review of the facility's policy and procedures titled, "Safety and Supervision of Residents," Revised in ...... revealed the policy statement: Our facility strives to make the environment as free from accident hazards as possible. Residents' safety and supervision and assistance to prevent accidents are facility wide commitment to safety at all levels of the organization. Facility oriented approach to safety included: "Employees shall be trained on potential hazards and demonstrate competency on how to identify and report accident hazards and try to prevent avoidable accidents. Individualized, resident-centered approach to safety included: 1. Our individualized, resident centered approach to safety addresses safety and accident hazards for individual residents, 2. The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accidents hazards or risks for individual residents, 3. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate

supervision and assistive devices. Systems approach to safety noted: 2. Resident supervision is a core of the systems approach to safety. Review of the care plans for Resident #1 revealed, care plan dated

# 1 exhibited behaviors of ...../agitation. Goals: Resident #1 will be able to display appropriate response to situations by next review date." Approaches included, determine cause of ..., observe for changes in mental status. ., and behavior, notify MD (Medical Doctor) of changes as needed. Further review of the care plans showed that Resident #1 had diagnoses of

STATE FORM caso FTRW12 If continuation sheet 30 of 35

· "Resident

Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R-C 111356 B. WING \_\_\_\_ 11/02/2021

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

CORAL REEF SUBACUTE CARE CENTER LLC 9869 SW 152ND STREET MIAMI, FL 33157				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 216}	Continued From page 30	{N 216}		
(n 216)	Continued From page 30  and was at risk for alterations in pattern. Approaches included, observe for changes in encourage verbalization of feelings, administer as ordered.  Record review of Resident #1's behavior monitoring sheets for and indicated that Resident # 1 was monitored for the behaviors afraid/panic. Related to the use of in Infligram (mg) tablet. There was no record to indicate that Resident #1 was monitored for any other behavior such as changes or danger to self. There was no behavior record to indicate that Resident #1 was monitored for langes or danger to self. There was no behavior record to indicate that he was monitored for his diagnosis of and for the use of Further review of the behavior monitoring sheets showed that Resident #1 had multiple episodes documented as "Afraid/Panic." The behavior monitoring sheet infliated on Resident #1 had a total of 9 episodes of Afraid/Panic Pive out of nine different episodes occurred during the hours of 7:00 AM to 7:00 PM on 17:20, and 25. Four different episodes of Afraid/Panic occurred between the hours of 7:00 PM to 7:00 AM on 27 and 28. The documented interventions for each episode noted "Routine."	(N 216)		
	documented an initiated date of but the behavior monitoring sheet showed no record (left blank) for , and during the day shift (7:00 AM to 7:00 PM) on			
	indicating that Resident #1's behavior "Afraid/Panic" was not monitored during that time. Further review of the behavior monitoring records			Various pussous out of the

AHCA Form 3020-0001

R-C

Agency for Health Care Administration
STATEMENT OF DEFICIENCIES (XT) PROVIDERSUPPLIERCLIA (XC) MULTIPLE CONSTRUCTION (XC) DATE SURVEY AS BUILDING: COMPLETED

AS BUILDING: COMPLETED

	111356	B. WING	11/02/2021
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STATE, ZIP CODE	

STREET ADDRESS, CITT, STREET, ZIP CO

CORAL REEF SUBACUTE CARE CENTER LLC 9869 SW 152ND STREET MIAMI, FL 33157					
(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)	(X8) COMPLETE DATE	
	REGULATORY OR LSC IDENTIFYING INFORMATION)		CROSS-REFERENCED TO THE APPROPRIATE		
	occurred during the day shift (7:00 AM to 7:00 PM) on and on the day of his Interventions for each episode noted "Routine OHS[Every hour of			endreda pota bota bota bota bota bota bota bota b	

AHCA Form 3020-0001

STATE FORM 699 ET8W12 If continuation sheet 32 of 35

Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R-C 111356 B. WING \_\_\_\_ 11/02/2021

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ORAL R	EEF SUBACUTE CARE CENTER LLC 9869 SW MIAMI, F	152ND STREET L 33157		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
(N 216)	Continued From page 32	{N 216}		
(N 216)	sleep]." Review of the progress notes for , showed no recorded documentation that addressed any of the episodes exhibited by Resident #1.  Review of the nurses progress notes dated at 11:00 PM documented by Licensed Practical Nurse (LPN) Staff C revealed: "Resident assigned CNA (Certified Nursing Assistant] was observed running over to me while I was doing my med pass as he verbalized code biue, I immediately assigned a staff member to call 911 as I grabbed the defibrillator machine. I assigned another staff member to get the crash cart. I ran to his room. The residents skin color was noted as pale color, no, was noted resident was transferred from wheelchair to the bed. Board was placed under the patient and [1] I was initiated. 911 arrived and EMT[Emergency Medical Technicians] pronounced his No obvious injuries were noted at the time of ON assigned to this resident verbalized that he was unable to enter his room. The CNA stated he had to push very hard to poen the door. CNA stated resident whelchair was pushed against the door with patient stifting in the wheelchair. Trash bag was noted over his CNA stated he removed the trash bag to see if patient was not breathing.	(N 216)		
	CNA then verbalized to me and to the police how he found the patient. Family was notified by police. Police officer spoke to [ Emergency Contact]. The medical examiner arrived and transferred residents' body out of the facility."			
	Review of the investigative report and interview with the Clinical Regional Nurse on at approximately 2:30 PM revealed, the Clinical regional nurse had reviewed the facility's video			

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Agency for Health Care Adminis	tration		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	111356	B. WING	R-C 11/02/2021

NAME OF P	ROVIDER OR SUPPLIER ST	TREET ADDRESS, 0	CITY, STAT	E, ZIP CODE	
CORAL REEF SUBACUTE CARE CENTER LLC 9869 SW 152ND STREET MIAMI, FL 33157					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PF	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 216}	Continued From page 33	{N 2	16}		-
	recording as she investigated the event. The Clinical Regional Nurse documented her observation of the video and reported that she reviewed the video recording on "Tuesday or Thursday last week." The report noted that on Saturday 2:54 PM Resident #11 SCNA, (Staff A) went into the residents' room [room #] at 4:18 PM. Nurse (Staff B) was passis meds. The Clinical Regional Nurse stated: "You can see her going in and out of rooms." At 4:30 PM the friend (Resident #4) leaves Resident #4 is room. His door enabled to the resident for the friend (Resident #4) favore. His door emained open the whole time. At 5:21 PM the Nurse [Staff B] went into Resident #1's room. His door emained open the whole time. At 5:21 PM the Nurse [Staff B] went into Resident #1's room. A 5:43 PM the CNA (Staff A) picked up the tray, (Noted that he ate 100%). At 6:25 PM it appeal the door is shut from inside the room. No one checked on the resident or attempted to enter throom from approximately 6:25 PM to 8:15 PM (Staff C) LPN was scheduled to start her shift at 7:00 PM, no indication that she checked on Resident #1 from the time her shift started until the CNA called her at around 8:15 PM. At 8:15 PM. the CNA that do to gus the door, so that do year is the door on one of the change of the control of a few second, leaves the area gets the door, but was blocked. The CNA that do to push the door open and when he entered, the room he noted Resident #1 seated in his wheelchair, unresponsive with a bag over his . The CNA stated that he pulled the bag off Resident #1's room where they transferred him to the bed, a seldaes as 911, staff responded to this resident's room where they transferred him to the bed, a lackboard was placed, and initiated. Law enforcement and EMTs responded shortly thereafter and pronounced this Resident. The	u d d d d d d d d d d d d d d d d d d d			

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PRINTED: 11/30/2021 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_\_ P.C B. WING 111356 11/02/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9869 SW 152ND STREET CORAL REEF SUBACUTE CARE CENTER LLC MIAMI, FL 33157 (X433F) SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (N 216) {N 216} Continued From page 34 Residents body was transferred to the Medical Examiner's office. During an interview on at 10:56 AM the Psychiatrist reported he did not review the above mentioned behavior monitoring sheets in Resident #1's clinical record. The Psychiatrist explained that he met with the facility's staff and discussed residents' behaviors and if any adjustments are needed. When asked about Resident #1, the Psychiatrist reported he was not aware that Resident # 1 had any behaviors. Upon discussion of the multiple documented episodes of afraid/panic noted on Resident #1's clinical record, the Psychiatrist reported he was not aware and that the nurses had not communicated the behaviors to him. The Psychiatrist explained that the facility staff should have communicated ..., afraid/panic episodes and any other behavior exhibited by Resident#1 to him, "If they tell me I would definitely do something. The nurses usually call me. They did not tell me about those episodes. Had I known, I would have definitely done something, I would have gone to see him, maybe change the medication ..." Class I

PRINTED: 11/30/2021 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_\_ P.C B MING 111356 11/02/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9869 SW 152ND STREET CORAL REEF SUBACUTE CARE CENTER LLC MIAMI, FL 33157 (X433F) SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (N 000) INITIAL COMMENTS (000 N3 An unannounced complaint survey for complaint numbers 2021013844 and 2021013886,was , through , at Coral Reef Subacute Care Center. The allegations for complaint number 2021013844 was substantiated without deficient practice and the allegations for complaint number 2021013886 was substantiated with deficient practice. Deficiencies were identified at Class I at the time of the survey. Class I deficiencies are those which the agency determines present an imminent danger to the residents of the facility or a substantial probability that .... or serious physical harm would result there from. The Class I deficiencies were identified at: N 204 - Scope and Severity (J) - Freedom from and Neglect N 201 - Scope and Severity (J) adequate and appropriate healthcare N 216 - Scope and Severity (J) Health and safety of Residents The facility's Administrator, Director of Nursing and Regional Nurse Consultant were notified of the Class I deficiencies on . . . . , at 5:54 PM

SS=J Appropriate Health Care

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

The following is a description of the non-compliance:

(N 201) 400.022(1)(I), FS Right to Adequate and

The facility census at the time of the survey was

TITLE (X6) DATE Electronically Signed /21

(N 201)

STATE FORM If continuation sheet 1 of 35 ET8W12

Agency f	or Health Care Adminis	stration				D: 11/30/202 MAPPROVE
STATEMENT	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE S COMPL	ETED
		111356	B. WING		R- 11/0	-C 02/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
CORAL R	EEF SUBACUTE CARE (	CENTER LLC 9869 SW MIAMI, F	152ND STREET L 33157	Т		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
(N 201)	health care and prote including social servic including social service with the resident care recognized practice s community, and with agency.  This Statute or Rule Based on interview at facility failed to ensu care needs was adec psychiatrist for one (for residents sampled as to effectively monitor behaviors related to for seident sampled as led to Resident #1 wifflicted self-harm an placing a trash bag oby	e adequate and appropriate citve and support services, zes, mental health services, zes, mental health services, excreational activities; and olititative services consistent plan, with established and tandards within the rules as adopted by the is not met as evidenced by: nd records reviewed, the re a resident's mental health justely supervised by a Resident #10 ut of ten evidenced by facility failure behaviors and report said Resident #15 diagnoses of , and episodes of ychiatrist. The facility failure lile unsupervised in his room of sufficeated himself by	{N 201}	N201  Corrective action: Resident #1 no longer resides in the facility Nursing Staff involved with Resident #1 care was educated to effectively mon behaviors related to diagnosis of and ., na addition: T Administrator/designee educated facilitation facilitation for the control of the contro	itor The lity for	

drugs. Physicians and physician -extenders (Ex. AHCA Form 3020-0001

receiving

.... medications and 47 residents

Record review of the facility's undated policies

and procedures titled, , , Medication,

the facility at the time of this survey.

general statement noted:

medications include any drug that affects

activities associated with meant process and

and classes of

The Findings Included:

behavior, including

medications residing in

Health Referral as needed

potential to be affected: Residents with a diagnosis of

to be affected.

Identification of other residents with

and/or , , or prescribed a medication have the potential

Current Residents who have a diagnosis

of . . . and/or . . . . . and are

prescribed a , , medication

are in place to identify behaviors.

behaviors and referrals made for

were audited to ensure behavior sheets

interventions placed to intervene with the

Agency for Health Care Adminis	tration		FORM APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	111356	B. WING	R-C 11/02/2021

		111356	B. WING		11/02/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ATE, ZIP CODE	
		9869 SW 1	52ND STREET	·	
CORAL R	EEF SUBACUTE CARE O	CENTER LLC MIAMI, FL			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 201}	Continued From page	2	{N 201}		
(N 201)	Physician Assistant, I medicat with the interdisciplina appropriate use, evail standards included: goal of determining the behavioral symptoms treatment of environm behavioral interventio sychopharmacologicutilized to meet the ne G. Psychopharmacologicutilized to meet the ne G. Psychopharmacologicutilized to meet the net with the procedures followed I physician, PA (Physic I) Nat (Physician, PA (Physic I) Nationale and diagnost arget symptoms. 4. interdisciplinary team	Aurse Practitioner) will use ions appropriately, working any team nurse to ensure uation, and monitoring.  C. The facility supports the ieu underlying cause of so the appropriate nental, medical and /or ns, as well as all medications can be eeds of individual resident, or all medications will be eeds of individual resident of the re	(N 201)	and mental health evaluations as needed Measures/Systematic Changes made to ensure non-reoccurrence: Policies: Accident & Incident- investigatio and Reporting and Behavioral Health services, Informed Care and -Clinical Protocol, Physician Services and Behavior Health Services were reviewed The Administrator/designee educated Licensed Nurses, Certified Nursing Aides and Social Services regarding behavioral health with emphasis on effectively monitoring residents with and diagnosis and to ensure referrals are made for mental health evaluations. The Administrator/designee educated the Licensed Nurses and certified nursing aides to monitor residents prescribed a melication for new or worsening behaviors, and to have those behaviors reported to the provider for a potential Mental Health referral as warranted and to ensure the resident's mental health care needs are adequately supervised by a psychiatrist/psychologist The Administrator/designee educated Licensed Nurses and Certified Nursing Aides regarding on the Physician Service policy and Behavioral Health Policry The Administrator/designee educated nursing staff and social services on informed care including a newly added questionnaire regarding	
	2. Will monitor for the	presence of target pasis. Behaviors will be		Newly hired staff will be educated during orientation by the DON/designee on behavioral health with emphasis on	

Agency fi	or Health Care Adminis	stration				: 11/30/2021 APPROVE
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION	(X3) DATE SI COMPLE	
		111356	B. WING		R-4 11/0:	C 2/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	ATE, ZIP CODE		
CORAL R	EEF SUBACUTE CARE O	CENTER LLC 9869 SW 1 MIAMI, FL	52ND STREET 33157	T		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
{N 201}	Continued From page	3	{N 201}			
	physician and the inte quarterly basis to dete presence of target be	f the medication with the erdisciplinary team on a ermine the continued havior and or the presence s of the medication use.		monitoring residents with a diagnosis , and/or and to enst referrals are made for mental health evaluations. Residents prescribed , , , , , , , , , , , , , , , , , , ,	ıre	

Record review of Resident #1's behavior monitoring sheets for ,, , , and ....., indicated that Resident # 1

team resident reviews of

will be performed on any resident and on

reported to the physician.

medications.

. . on a quarterly basis change will be

develop behavioral care plans that include

individualized non-pharmacological interventions.

Social Services: Coordinates the interdisciplinary

was monitored for the behaviors afraid/panic. Related to the use of . . . . . . . 1 milligram (mg) tablet. There was no record to indicate that Resident #1 was monitored for any other behavior such as changes or danger to self. There was no behavior record to indicate that he was monitored for his diagnosis of and for the use of Further review of the behavior monitoring sheets showed that Resident #1 had multiple episodes documented as "Afraid/Panic". The behavior monitoring sheet initiated on ..... indicated Resident #1 had a total of 9 episodes of Afraid/Panic. Five out of nine different episodes

occurred during the hours of 7:00 AM to 7:00 PM

on . . , . . , 17, 20, and 25. Four different

episodes of Afraid/Panic occurred between the

hours of 7:00 PM to 7:00 AM, on ..., ..., 27

and 28. The documented interventions for each

Review of the nurses' progress notes for the

episode noted "Routine."

The DON/designee will audit residents with a diagnosis of ... and/or , and prescribed a , , medication to ensure behavior monitoring sheets accurately reflect the resident's behaviors and to ensure the provider are notified of any new or worsening behaviors for a potential mental health referral weekly X 4 then Monthly x3 Social Services/designee will audit newly admitted residents for informed screen weekly X4 monthly X 3. The DON/designee and Social Services/designee will present the results

of audits to the QAPI committee for review

clinical meeting for new or worsening

behaviors to ensure the behaviors are

reported to the provider for a potential

to ensure the resident's mental health

a psychiatrist/psychologist

Mental Health referral as warranted, and

care needs are adequately supervised by

New admissions will be reviewed during clinical meeting for . . . Informed Care assessment and behavioral Monitoring as indicated per diagnosis of . . . , and/or

health will be initiated to ensure the

adequately supervised by a

Monitoring of Corrective Action:

psychiatrist/psychologist

residents Mental Health care needs are

and referrals to behavioral

PRINTED: 11/30/2021 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: P.C B MING 111356 11/02/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9869 SW 152ND STREET CORAL REEF SUBACUTE CARE CENTER LLC MIAMI, FL 33157 (X433ID) SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) {N 201} Continued From page 4 (N 201) and feedback. month of ..., showed no record that addressed any of the episodes of Responsible party: DON/Designee and Social Services/Designee exhibited by Resident #1. Review of the behavior sheets for ... documented an initiated date of ......... but the behavior monitoring sheet showed no record (left blank) for ...., ..., and during the day shift (7:00 AM to 7:00 PM) on ... indicating that Resident #1's behavior "Afraid/Panic" was not monitored during that time. Further review of the behavior monitoring records for J... showed that Resident #1 had 15 different episodes of Afraid/Panic during the 7:00 PM to 7:00 AM shift. The Afraid/Panic behaviors noted to have occurred on ....., 9, 10, 11, 13, 15, 16, 17, 18, 19, 22, 23, 24, 25 and 29. Review of the nurses' progress notes for ......, showed no recorded documentation that addressed any of the afraid/panic episodes exhibited by Resident #1.

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PM on ,

7:00 AM) on

by Resident #1.

Review of Resident # 1's behavior sheets for .... (initiated on .....) showed Resident #1 had a total of 17 different episodes of Afraid / Panic during the month of . Four out 17 different episodes of Afraid/Panic occurred between 7:00 AM to 7:00

documented noted "Routine QHS [nightly at bedtime]". Further review of behavior monitoring record showed that Resident #1 had 13 out of 17 different episodes of Afraid/Panic during the evening shift (7:00 PM to

20, 21, 24, 26, 27 and 28. The documented intervention noted "Refer to Nurses Notes." Review of Nurses Notes for ..... showed no recorded documentation that addressed the episodes of afraid/panic exhibited

, 3, 4, and 5. The intervention

. 7. 12. 13. 14. 17. 19.

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PRINTED: 11/30/2021 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_\_ P.C B MING 111356 11/02/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9869 SW 152ND STREET CORAL REEF SUBACUTE CARE CENTER LLC MIAMI, FL 33157 (X433ID) SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (N 201) Continued From page 5 (N 201) Review of the behavior monitoring sheet dated ....., showed that Resident#1 had a total of three Afraid/Panic episodes. Resident #1 had one episode of Afraid/Panic between 7:00 PM to 7:00 AM on #1 had two episodes of the Afraid/Panic that occurred during the day shift (7:00 AM to 7:00 PM) on . . . . and on the day of his . . . , . Interventions for each episode noted "Routine QHS." Review of the progress notes for , showed no recorded documentation that addressed any of the episodes exhibited by Resident #1. On at 12:15 PM, during an interview and record review with the Director of Nursing (DON), and the Clinical Regional Nurse. The DON explained: the nurses on the floor usually complete the behavior monitoring sheets. The nurses are the ones that monitor and document the behaviors. the CNA would report each behavior to the nurses. Behaviors that are reported and documented are behaviors that are unusual for the patient and any behavior that might put the patient in distress, such as

needed.

The clinical records were discussed related to the Plan of care the DON explained diagnoses of ..., ..., depends on the patient. For just about anybody, the care planned interventions include provide emotional support. Activities, whatever they are interested in encouraging them to talk about their feelings. Encourage socialization, provide feedback to reinforce positive behaviors. Notify MD of changes as

Review of the investigative report and interview with the Clinical Regional Nurse on approximately 2:30 PM revealed, the Clinical

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FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R-C 111356 B. WING \_\_ 11/02/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

9869 SW 152ND STREET

CORAL R	FEF SUBACUTE CARE CENTER LLC	W 152ND STREET FL 33157		
(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 DEFIGIENCY)	(X5) COMPLETE DATE
{N 201}	Continued From page 6 regional nurse had reviewed the facility's video recording as she investigated the event. The Clinical Regional Nurse documented her observation of the video and reported that she reviewed the video recording on "Tuesday or Thursday last week." The report noted that on Saturday at 2:54 PM Resident #1's CNA, (Staff A) went into the residents' room [room #] at 4:18 PM. Nurse [Staff B] was passing meds. The Clinical Regional Nurse stated: "You can see the regioning and out of rooms." At 4:30 PM the friend [Resident #4] leaves Resident #1's room. The video showed that at 4:52 PM meal was	(N 201)		
	delivered to Resident #1's room. His door remained open the whole time. At 5:21 PM the Nurse [Staff B] went into Resident #1's room. At 5:43 PM the CNA [Staff A] picked up the tray, (Noted that he at 100%). At 6:25 PM it appears the door is shut from inside the room. No one checked on the resident or attempted to enter the room from approximately 6:25 PM to 8:15 PM [Staff C], LPN was scheduled to start her shift at 7:00 PM, no indication that she checked on Resident #1 from time her shift started until the CNA called her at around 8:15 PM. At 8:15 PM, the CNA tried to get into the room and noted that the door was closed. The CNA tried to open the door, but it was blocked. Staff Awas in the room for a few second, leaves the area, gets the nurse and the crash cart. The Regional nurse			
	explained that The CNA had to push the door opened and when he entered, the room he noted Resident #1 seated in his wheelchair, unresponsive with a bag over his . The CNA stated that he pulled the bag off Resident #1's and ran to get help. A code was called as well as 911, staff responded to this resident's room where they transferred him to the bed, a backboard was placed, and . initiated. Law enforcement and EMTs [Emergency Medical			NATIONAL PROPERTY OF THE PROPE

11/02/2021

Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R-C

B. WING \_\_\_\_\_

111356

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE					
CORAL R	FEE SUBACUTE CARE CENTER LLC	SW 152ND STREET I, FL 33157			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{N 201}	Continued From page 7	{N 201}			
	Technician] responded shortly thereafter and pronounced this Resident, The Residents body was transferred to the Medical Examiner's office.				
	On				
	days that I worked. I filled it out on , , the day that he , . What I documented was that he had one behavior of ," Staff B, RN explained that Resident #1 kept asking about the				
	( ) treatment. The intervention, during the , episode was teaching about the reason for the treatment, what was the reason, and why he remained in isolation. Staff B stated that her documentation on the behavior monitoring sheets about the afraid/panic episode was related to the treatment, that Resident #1 received the treatment and that it was effective. Staff B stated: "I did not document."				

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Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R-C B. WING \_\_\_\_\_ 111356 11/02/2021

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
CORAL R	CORAL REEF SUBACUTE CARE CENTER LLC  9869 SW 152ND STREET MIAMI, FL 33157					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE		
{N 201}	Continued From page 8 in the nurses notes that the resident was having episode of , because I did my action, I did not see him to be desperate, he allowed me to administer his treatment." Staff B reported that the purpose of the behavior monitoring sheet is	{N 201}				
	to follow for a prescribed medication, and document the episodes related to the behavior, for which the resident is taking the medication. The intervention was to refer to nurses notes. Staff B agreed there was no record to explain anything about the resident's or behavior. Staff B stated: "It's					
	established that a patient can have at least three small episodes of, we take action if they have a big one. Big ones we would document on the nurses' notes. The purpose of the behavior monitoring sheet is to see if the medication seems effective throughout the monthwhat the					
	behavior monitoring sheet shows is that the medication is effective. I documented that he had on on some shows the behavior of the shower of t					
	not reflect the exact nature, or details of the behavior, she did not know and could not recall the behavior. Staff B stated: I also documented no behavior on 10th, 11th, 16th, 17th, 24th, 25th, 26th. When I noticed the					
	behavior, I did not report to anyone. I did not think that I needed to communicate it to the psychiatrist. We did not monitor him for I did not know he had any or diagnoses of With					
	a diagnosis of "Staff B explained that she would have reacted differently and that					

PRINTED: 11/30/2021 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_\_ P.C B MING 111356 11/02/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9869 SW 152ND STREET CORAL REEF SUBACUTE CARE CENTER LLC MIAMI, FL 33157 (X433F) SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (N 201) Continued From page 9 (N 201) not reject care, or complaint of ..... " Upon discussion of Resident #1's Diagnoses, Staff B reported: "I am surprised that he had diagnosis ...when I left on that day he remained in his bed. I went in to see him at approximately 7:10 PM he was in his room, he asked we close the door," (Investigative report and interview with The Clinical Regional Nurse on at approximately 2:30 PM showed that per surveillance video, Staff B last saw the resident in his room at approximately 5:21 PM). the Psychiatrist reported he did not review the above mentioned behavior monitoring sheets in Resident #1's clinical record. The Psychiatrist explained that he met with the facility's staff and discussed residents' behaviors and if any adjustments are needed. When asked about Resident #1, the Psychiatrist reported he was not aware that Resident # 1 had any behaviors. Upon discussion of the multiple documented episodes of afraid/panic noted on Resident #1's clinical record, the Psychiatrist reported he was not aware and that the nurses had not communicated the behaviors to him. The Psychiatrist explained that the facility staff should have communicated , afraid/panic episodes and any other

message was left. On

behavior exhibited by Resident#1 to him. "If they tell me I would definitely do something. The nurses usually call me. They did not tell me about those episodes. Had I known, I would have definitely done something, I would have gone to see him, maybe change the medication at 12:13 PM attempted to interview Staff C, LPN by phone and a voicemail

Staff C was called again and Staff C answered

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at 5:04 PM

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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:		COMPLETED
	111356	B. WING	R-C 11/02/2021

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NAME OF P	ROVIDER OR SUPPLIER	STREET ADDRES	S, CITY, STAT	E, ZIP CODE	1
CORAL R	EEF SUBACUTE CARE CENTER LLC	9869 SW 152N MIAMI, FL 331			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
(N 201)	Continued From page 10  the phone and requested for the surveyor to in 15 minutes. On 5:24 PM C was called, Staff C was asked if Residenthad any complaints of while under her of Staff C responded, "nol never, he never had complaints." When asked to clarify her note that the resident had the call was disconnected. On the call was for your propers of your while under care. Staff C reported, "no!" Staff C was as to clarify the police because he was complaining of so much. "Staff C was as to clarify the documentation because the not indicated that the resident had called the polic Staff C, I.PN then explained that the police we called to help Resident #1 calm down while is helped him transfer to the hospital.	call staff #1 #1 staff #1 #1 staff #1 #1 staff #1 #1 staff #1 staff staf	1 201}		
(N 204) SS=J	400.022(1)(o), FS Right to be Free from, etc  (o) The right to be free from mental and , , corporal punishment, extended involuntary, and from physical and chemical except those authorized in writing by a physician for a spe authorized in writing by a physician for a spe and limited period of time or as are necessite by an emergency. In case of an emergency, may be applied only by a qualified licensed nurse who shall set forth in writing the content of the co	cified ated	1 204}		

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PRINTED: 11/30/2021 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: P.C B MING 111356 11/02/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9869 SW 152ND STREET CORAL REEF SUBACUTE CARE CENTER LLC MIAMI, FL 33157 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) {N 204} Continued From page 11 (N 204) circumstances requiring the use of ..... and, in the case of use of a chemical physician shall be consulted immediately may not be used in lieu of staff supervision or merely for staff convenience. for punishment, or for reasons other than resident protection or safety. This Statute or Rule is not met as evidenced by: Based on interviews, observations and records N204 reviewed, the facility failed to provide care, Resident #1 no longer resides in the services, and supervision to prevent one resident (Resident #1) out of 10 residents Administrator/designee Licensed Nursing sampled. The facility failed to effectively monitor Staff, and Social Services regarding behaviors related to Resident #1's diagnoses of behavioral health with emphasis on and , which lead to his decline monitoring residents prescribed and self-inflicted harm. While unsupervised in his ..... and . room, Resident #1 suffocated himself by placing

The Findings Included: Record review of the Facility's

or nealect ..."

the policy of the facility to protect all residents from physical or mental . . . . , involuntary , neglect or misappropriation of personal property...Neglect is defined as failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Preventive measures included: The assessment. care planning, and monitoring of residents with needs and behavior which might lead to conflict

a trash bag over his ..., resulting in .... by

Record review of the facility's policies and procedures revealed the (undated) policy Name: ..... Medication. The General Statement of Policy noted; medications include

medications and identifying possible risk factors and changes in ... and behavior as well as side effects. Administrator/designee in serviced all staff and Neglect, Nurse consultant educated administrative staff on . . . . and neglect. informed care and behavioral health. Residents with a diagnosis of

affected. The facility has conducted an audit of all current residents with a diagnosis of ... and ... who are prescribed medication to ensure they have an effective plan of care in conjunction with implementing policies and procedures to

..... have the potential to be

identify risk factors and change in

/behavior. In addition, side effects and effectiveness of medications and behavior monitoring sheets were audited to ensure behaviors Agency for Health Care Administration (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED A. BUILDING: R-C

		111356	B. WING		11/02/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADJ	DRESS, CITY, STA	TE. ZIP CODE	
TO SAIL OF T	TOVIDEN ON OUT FEET		52ND STREET		
CORAL R	EEF SUBACUTE CARE O	ENTER LLC MIAMI, FL			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
{N 204}	Continued From page	12	{N 204}		and the same of th
	with process and beh classes physician -extenders Nurse Practitioner) wit medications appropria interdiscipilinary beam use, evaluation, and 7 standards included: C. The facility support the underlying cause the appropriate treatmedical and /or behat as psychopharmacold utilized to meet the G. Psychopharmacold used to enhance the cand will never be used discipline or convenie Physician, PAIPhysicial, PAIPhysicial, PAIPhysicial, PAIPhysicial, PAIPhysicial, PAIPhysicial, Today and diagnost arget symptoms. 4.1 interdisciplinary team, undicational and diagnost arget symptoms. 4.1 interdisciplinary team, undications, or a support of the procedures Followed health included: Item facility in establishing use, dosage and mon medications. Item nur develop behavior mar Procedures Followed 1. Monitors , any adverse effects s' any adverse effects s' any adverse effects s'	and so of drugs. Physicians and (Ex. Physicians and (Ex. Physicians and (Ex. Physicians Assistant, ill use,		are documented and side effects are monitored.  Social services and nursing staff was educated by the Administrator/designee on informed care including a newly added questionnaire regarding Policies: Resident Neglect and Policy Informed Care, Behavioral Health Services, Medication, Clinical Protocol, Care Plans, Comprehensive Person-Centered Administrator/designee educated Licensed Nursing Staff, and Social Services regarding behavioral health will emphasis on monitoring residents prescribed and redications and identifying possible risifactors and changes in and medications and identifying possible risifactors and changes in and efficacy of medication Administrator/designee educated all star on and Neglect. Nurse consultation and neglect, informed care and behavioral health. Newly hired staff will be educated during residents with diagnosis of and medication and neglect, informed care and behavioral health. Newly hired staff will be educated during residents with diagnosis of and medication and residency of and medications as well as informed care.  Social Services/designee completed informed screening on all currentesidents.	h f f t t c r c ts
	any adverse effects si somnolence or function			residents. New admission will have a	

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PRINTED: 11/30/2021 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: P.C B WING 111356 11/02/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9869 SW 152ND STREET CORAL REEF SUBACUTE CARE CENTER LLC MIAMI, FL 33157 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMBLETE PREFEX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) {N 204} Continued From page 13 (N 204) 2. Will monitor for the presence of target informed screening completed behaviors on a daily basis. Behaviors will be During the clinical meeting any changes documented as warranted. noted in resident's ... and behavior, 3. Reviews the use of the medication with the noted side effects, or any changes in the physician and the interdisciplinary team on a effectiveness of the resident's quarterly basis to determine the continued . or . medication presence of target behavior and or the presence will be communicated to the practitioner of any adverse effects of the medication use. for potential mental health referral. During the clinical meeting, new admission will be performed on any resident on will be reviewed to ensure a .... on a quarterly basis changes and will informed screen was completed be reported to the physician. The DON/designee will audit current 5. develop behavioral care plans that include residents with a diagnosis of . individualized non-pharmacological interventions. weekly x4 and monthly x3 to Social Services: Coordinates the interdisciplinary ensure behavior sheets reflect the team resident reviews of , ., resident's behaviors, that those behaviors medications. have interventions placed to intervene with the behavior and any side effects of ..... and .

medications are monitored.

review and feedback

The DON/designee will report the results

of the audits to the Quality Assurance and

Performance Improvement Committee for

Responsible Party: DON/designee

Date of Compliance

revealed, he was admitted to the facility on . Clinical diagnoses included but were not limited too, ..... and ....,

Record review of Resident # 1's

(blockage in the \_\_\_\_, tract), and ..... . . . . . .

sheet

Record review of the Medication Administration and Treatment Record for Resident #1 revealed. medication included: 1 mg (milligram) tablet ordered 1

tablet to be given by ... at bedtime for diagnosis of

..... 50 mg tablet ordered 1 tablet to be every day at bedtime for a given by diagnosis of .......

5 milligram tablet, ordered 2 tablets to be given by .... twice a day for diagnoses of Record review of the Comprehensive Minimum

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	111356	B. WING	R-C 11/02/2021
AME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STATE, ZIP CODE	

NAME OF PROVIDER OR SUPPLIER

## 9869 SW 152ND STREET C

CORAL R	CORAL REEF SUBACUTE CARE CENTER LLC 9869 SW 152ND STREET MIAMI, FL 33157						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE			
{N 204}	Continued From page 14  Data Set (MDS) and interview with the MDS coordinator, Staff H on at 9.48  Alf revealed, Resident #1 was Re-admitted to the facility on In his most recent comprehensive MDS, dated He had a score of 15 on the Further review of the MDS revealed that Resident #1 had a clear speech pattern and was able to understand others as well as make self-understood. His active diagnoses included (, ), and but the MDS did not include the diagnosis of Review of the care plans for Resident #1 revealed a care plan dated ;"Resident #1 explanded a description of / Agitation. Coals: Resident #1 will be able to display appropriate response to situations by next review date." Approaches included, Determine cause of Observe for changes in mental status, and behavior, Notify MD [Medical Doctor] of changes as needed. Further review of the care plans showed that Resident #1 had diagnoses of and was at risk for alterations in pattern. Approaches included, observe for changes in encourage verbalization of feelings, administer so ordered. There were no care plans for the diagnoses of tablett.	{N 204}					
	Record review of Resident #1's Behavior Monitoring Sheets for the months of , indicated that Resident # 1 was monitored for the behaviors afraid/panic. Related to the use of  mg 1 tablet. There was no record to indicate			de qui esta frança de la constanta de la const			

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STATE FORM cesso ET8W12 If continuation sheet 15 of 35 Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R-C B. WING 111356 11/02/2021

NAME OF PROVIDER OR SUPPLIED

NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
CORAL REEF SUBACUTE CARE CENTER LLC		9869 SW 152ND STREET				
O O NAL II	EL BODAGO L BAILE GEN (EN EEG	MIAMI, FL 33157				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUL REGULATORY OR LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIGIENCY)	(X5) COMPLETE DATE		
{N 204}	Continued From page 15	{N 204}				
	that Resident #1 was monitored for any other behavior such as changes or danger to self.					
	mg tablet. Further review of Behavior Monitoring Sheets showed the resident had multiple episodes documented as "Afraid/Panic". During the Mo of (Initiated on ) Residen had a total of 9 episodes of Afraid/Panic. Five of rinie different episodes occurred between thours of 7:00 AM to 7:00 PM, on 20, and 25. Four different episodes of Afraid/Panic occurred between 7:00 PM to 7:04 AM, on 27 and 28. Interventions each episode noted "Routine", indicating that facility's only intervention was the administration of his routine medication: 1 mg tablet by at bedtime. For Diagnosis of	or 50 50 50 50 50 50 50 50 50 50 50 50 50				
	Record Review of the Nurses Progress Notes from to showed no recorded documentation that addressed any of the episodes of exhibited by Resident Review of behavior monitoring sheet for (Initiated on showed no record and was left blank for and was left blank for and was left blank for charged the progress of the progre	of #1.				

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Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R-C 111356 B. WING \_\_\_ 11/02/2021

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NAME OF PE	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STAT	E, ZIP CODE	
CODAL DI	EEF SUBACUTE CARE CENTER LLC	9869 SW 1	52ND STREET		
CORAL RI	EEF SUBACUTE CARE CENTER LLC	MIAMI, FL	33157		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY F REGULATORY OR LSC IDENTIFYING INFORMATION OF THE PROPERTY OF THE PROP	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
		urred 2, 23, y of the ent #1.  ne odes 117 s of 5 y of 7:00 ention ) ) was ; at had nic M) that 19, noted		CROSS-REFERENCED TO THE APPROPRIATE	COMPRETE
	episodes of Afraid/Panic occurred during th	e day and on nt #1			

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PRINTED: 11/30/2021 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: P.C B MING 111356 11/02/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9869 SW 152ND STREET CORAL REEF SUBACUTE CARE CENTER LLC MIAMI, FL 33157 (X433ID) SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) {N 204} Continued From page 17 (N 204) interventions for each episode noted "Routine QHS." indicating that the facility's only intervention was the administration of his routine medication: 1 mg tablet by ... at hedtime. Review of the progress notes for showed no record that addressed the afraid/panic episodes exhibited by Resident #1. Further review the nurses progress notes dated with time noted as 11:00 PM documented by LPN, Staff C revealed: "Resident assigned CNA [Certified Nursing Assistant] was observed running over to me while I was doing my med pass as he verbalized code blue. I immediately assigned a staff member to call 911 as I grabbed the defibrillator machine. I assigned another staff member to get the crash cart. I ran to his room. The residents skin color was noted color, no was noted resident was transferred from wheelchair to the bed. board was placed under the patient and [ . . . . . ] was initiated.

911 arrived and EMT/Emergency Medical Technicians] pronounced his . . . . No obvious injuries were noted at the time of assigned to this resident verbalized that he was unable to enter his room. The CNA stated he had to push very hard to open the door. CNA stated resident wheelchair was pushed against the door with patient sitting in the wheelchair. Trash bag

the trash bag to see if patient was not breathing. Patient was not breathing per CNA statement. CNA then verbalized to me and to the police how he found the patient. Family was notified by police. Police officer spoke to [Emergency Contactl. The medical examiner arrived and

. CNA stated he removed

was noted over his

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Agency f	or Health Care Adminis	tration				): 11/30/2021 1APPROVE
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE S COMPLI	
		111356	B. WING		R- 11/0	C 2/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET 4	DDRESS, CITY, STATE	ZIR CODE		
TO SWE OF T	TO VIDER OR OUT LIER		152ND STREET			
CORAL R	EEF SUBACUTE CARE (	CENTER LLC MIAMI, F	L 33157			
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{N 204}	Continued From page	18	{N 204}			
	transferred residents'	body out of the facility."				
	with the Clinical Region approximately 2:30 P nurse reviewed the fa she investigated the cobservations of the vi Nurse reported that succording on "Tuesda The investigative reperied that succording on "Tuesda The investigative reperied that succording on "Tuesda The investigative reperied that succording on "Tuesda The investigative regions" at 4:54 PM leaves Resident #1"s room. His Door time. At 5:21 PM face at 4:542 PM meal #1"s room. At 5:43 PM the CNA Noted that he ate 100 the door is shuf from checked on the resider on from approxima (Staff C. LPN) was sc. 7:00 PM, no indicatic	pative report and interview a noal Nurse or noal Nurse or noal of revealed, the regional citility's video recording as event. She documented her deo. The Clinical Regional he reviewed the video yo or Thursday last week." you not noted that on Saturday IR Resident #1's. Certified 4A) (Staff A) went into the #1 at 4:18 PM. Nurse Nurse (RN)was passing her going in and out of the friend (Resident #4) room. The video showed was delivered to Resident remained open the whole Nurse (Staff B) went into [Staff A] picked up the tray. %. At 6.25 PM it appears inside the room. No one and or attempted to enter the telep 6:25 PM to 8:15 PM heduled to staft her shift at that she checked on CNA called her at around				

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8:15 PM. At 8:15 PM. the CNA tried to get into the room and noted that the door was closed. The CNA tried to open the door, but it was blocked. (Staff A) was in the room for a few second, leaves the area gets the nurse and the crash cart... The Regional nurse explained that the CNA had to push the door open and when he entered, he noted Resident #1 seated in his wheelchair. unresponsive with a bag over his

stated that he pulled the bag off Resident #1

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.. The CNA

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AM -3:00 PM and from 3:00 PM to 11:30 PM. He continued on Saturday to again work from 7:30 AM to 11:30 PM. Staff A explained. "on from my break which is from 8:00 PM to 8:30 PM, when I came ... and was doing my rounds and noticed that the door would not open. I spoke to one of the CNAs. He recommended; I pushed the door. I thought he might have blocked the door with something. When I finally opened the door, I noticed the resident was sitting in his chair with a plastic bag over his ..... The wheelchair was locked. He normally had two trash containers, one on each side of his bed, with plastic bag inside of it. Once I opened the

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Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R-C B. WING

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
CORAL R	CORAL REEF SUBACUTE CARE CENTER LLC 9869 SW 152ND STREET MIAMI, FL 33157						
(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 DEFIGIENCY)	(X5) COMPLETE DATE			
(N 204)	Continued From page 20 door, I notice the plastic bag on his I took the plastic bag; I threw it on the floor and cried for help. The floor nurse was on the hallway. We went to get the cash cart. She called code blue. The nurse and I transferred the resident from the wheelchair, they initiated the They all continued until the ambulance arrived. The police arrived they interviewed me. I could not leave the facility until after the detective interviewed me. Staff A. CNA explained that sometimes Resident #1 was aggressive and had behaviors like refusing care such as he refused a haircut and refused to shave and Staff A convinced Resident #4 and allowed Staff A to shave him. Staff A added "not that long ago, maybe two weeks", (Resident #1) would sometimes get angry and yell at staff; "like one time, he took off his gown and threw at me, I told the nurse on the floor about the behavior and asked her to come to the room and help me translate. I explained to [Resident #1] that I was here to take care of him, and that there was no need to be aggressive toward me, [Resident#1] understood and even	(N 204)					
HCA Form 3	apologized."  On at 12:15 PM, during an interview with the Director of Nursing ( DON) and the Clinical Regional Nurse, the DON explained; The nurses on the floor usually complete the behavior monitoring sheets. The nurses are the ones that monitor and document the behaviors. The CNA would report each behavior to the nurses.  Behaviors that are reported and documented are behaviors that are unusual for the patient and any behavior that might put the patient in distress, such as, The plan of care for diagnoses of, depends on the patient. For just about anybody, the care planned interventions include provide emotional support for all staff. For						

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R-C 111356 B. WING \_\_\_ 11/02/2021

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

CORAL REEF SUBACUTE CARE CENTER LLC 9869 SW 152ND STREET MIAMI, FL 33157							
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE			
{N 204}	Continued From page 21	{N 204}					
(n Zuel)	activities, it is whatever the residents are interested in. Encourage them to talk about their feelings. Encourage socialization. Provide feedback to reinforce positive behaviors. Notify MD ( Medical Doctor) of changes as needed. Psych consult as needed and Administer as ordered. During the interview, record review of Resident #15 clinical record showed, Resident #15 physician orders included: 1. 1 mg tablet, 1 tablet by at bedtime for diagnosis of and 50 mg tablet, for diagnosis of , and 50 mg tablet, for diagnosis of , give 1 tablet by every day at bedtime. The DON and Clinical Regional Nurse was asked about Resident #15 clinical record that showed no plan of care that specifically addressed his use of , or his diagnosis of , or Both the DON and clinical Regional Nurse agreed there was no care plan on record specific to the use of the control of t	(N 204)					
	and continued record review of Resident #1's clinical record, the DON explained; "We have						

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PRINTED: 11/30/2021 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: P.C B MING 111356 11/02/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9869 SW 152ND STREET CORAL REEF SUBACUTE CARE CENTER LLC MIAMI, FL 33157 (X433ID) SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) {N 204} Continued From page 22 (N 204) . . , it shows that we monitor for behaviors "Fear/Panic, , kind of stuff." According to the nurse's documentation on the Behavior Monitoring Sheets Resident #1 had panic/ episodes," The DON explained: "The nurses and general staff reported that the resident was showing frustration over his health. He did not like . He did talk about it sometimes. He had ...., on ..... and 2nd. The only intervention was the medication as documented on the Behavior Monitoring Sheets ... We do not have a behavior monitoring record for the use of Regional Nurse both agreed to review the residents record for any notes that addressed Resident #1's behaviors, and acknowledged there were no actual written notes that addressed any of the resident's behaviors or DON and the Clinical Nurse Manager agreed such documentation was necessary.

no indication that he was depressed, and that the facility staff was "usually very good at letting us know when there is any indication, not only present, but also past history, or any indication of . They usually call me for an clinical , evaluation. I see most of the patients that are , they usually generate a consult for me. If the patient had shown any signs or symptoms, indicating they had clinical or the staff would

at 12:05 PM, during an interview the Psychiatrist explained that Resident #1 gave

have notified me." The Psychiatrist acknowledged that he saw Resident #1 once, on ..... and that his diagnoses included and ..... A continued interview with the Psychiatrist on at 10:56 AM revealed

the psychiatrist did not review the above-mentioned Behavior Monitoring Sheets Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R-C B. WING \_\_\_\_\_ 111356 11/02/2021

NAME OF PI	ROVIDER OR SUPPLIER STREET	ADDRESS, CITY, STAT	TE, ZIP CODE				
CORAL REEF SUBACUTE CARE CENTER LLC 9869 SW 152ND STREET MIAMI, FL 33157							
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{N 204}	Continued From page 23	{N 204}		on the same of the			
	found in Resident #1's clinical record. The Psychiatrist explained that he met with facility staff and discussed residents behaviors and if any adjustments are needed. The Psychiatrist was asked about Resident #1's behaviors. The Psychiatrist reported he was not aware that Resident #1 had any behaviors. Upon discussion of multiple documented episodes of afraid/panic noted on Resident #1's clinical records the psychiatrist reported he was not aware of any of the documented behaviors and stated that the nurses did not communicate any artificial properties of the discourant properties have some and the facility staff should have communicated any artificial properties have some and the facility staff should have communicated any artificial properties with the facility staff should have communicated any artificial properties with the facility staff should have communicated any artificial properties with the facility of the document of the facility session with the facility of the document of the facility assessment dated and interview with the facility's Social Services Staff; Social Services Assistant (SSA), Staff F, it was revealed that social services is responsible for assessing the residents upon admission, quarterly, and annually. The SSD revealed social services as services as assessing the residents proportion around the facility, assession (Brief Interview of Mental Status) score, moods, and behaviors. The SSD stated he went to the residents from to complete the nititial services will be available to Resident #1 and family for support if needed. The						
	and assessment indicated the resident had tittle interest or pleasure in doing things,						

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them." Interview on

the facility since

learned about residents concerning behaviors during morning meetings and never knew that he had any behaviors. When asked why there was only one social services assessment and progress note in Resident #1's clinical record, the SSD responded. "There must have been other progress notes. I don't know what happened to

Staff B Registered Nurse(RN) reported working in

, at 10:01 AM with

, this year and normally

Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R-C 111356 B. WING \_\_\_\_ 11/02/2021

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

CORAL REEF SUBACUTE CARE CENTER LLC 9869 SW 152ND STREET MIAMI, FL 33157					
(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 DEFIGIENCY)	(X5) COMPLETE DATE	
{N 204}	Continued From page 25	{N 204}		and the same of th	
the world	continued rhom page worked with (Resident #1) three days a week, from 7:00 AM to 7:00 PM. The resident was alert and oriented times three. He communicated his needs well. He normally slept until about 9:00 AM/10:00 AM. He liked to participate in, and activities. He liked to come out of the room. On the day of the incident (Resident #1) was on isolation precautions due to a ( ) Staff B, RN stated, "I worked from Thursday, to Saturday. I monitored for behaviors related to his use of we monitored for fear, or I don't remember him having any behavior. He sometimes would get a little upset with the CNAs, asked that we closed the door, close the window, or yell, don't touch me! Generally, I document if the patient's behavior is constant. Normally, he was easily re-directed," Staff B, RN reported not being present when Resident #1 had the aggressive behavior of throwing his gown at Staff A, CNA. "I did complete the behavior monitoring sheet for the resident on the days that I worked. I filled it out on and the day that he was asking a lot about why he remained with the treatment, about the ( ). He kept asking about it, although I had already spoken to him about it. The intervention, during the episode was teaching about the reason for the treatment, what was the reason, and why he remained in soldition. What I documented on the behavior monitoring sheets soon, and why he remained in soldition. What I documented on the behavior monitoring sheets about afraid/panic episode was teaching about the reason for the treatment, what was the reason, and why he remained in soldition. What I documented on the behavior monitoring sheets shout afraid/planic episode was related to the treatment and that it was effective. I did not document on the nurses notes that the resident was having an episode of	, ve comp			

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cause them to have a crisis. " On that day he seemed well. he did not seem depressed, he did AHCA Form 3020-0001

notes. The purpose of the behavior monitoring sheet is to see if the medication seems effective throughout the month. What the behavior monitoring sheet shows is that the medication is effective. I documented that he had . . . . on , 3rd, and 4th. The one episode could have been something like, "I don't want to shower. I don't know the behavior." Staff B agreed that the documentation does not reflect the exact nature, or details of the behavior, she did not know, could not recall. Staff B added, " I also documented no behavior on 10th, 11th, 16th, 17th, 24th, 25th, 26th. When I noticed the behavior. I did not report to anyone. I did not think that I needed to communicate it to the Psychiatrist. We did not monitor him for .... I did not know he had any or diagnoses of

B then explained that with a diagnosis of she would react differently because ..... are very dangerous, levels of

in a person's

." Staff

can change and

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Staff C was asked whether or not the resident ever expressed or showed any signs or symptoms of or or while under her care, Staff C again reported, "no", when asked about her handwritten nurses' notes dated 12:00PM Staff C, stated: "oh yeah.

Record review revealed Resident #1 was under the care of Staff C Licensed Practical Nurse (LPN) one of the two times it was documented that Resident #1 called the police because he

) and on the night

attempted to conduct a telephone

was in so much . (

telephone interview on

interview with Staff C, LPN on at 12:13 PM and a voice message was left. On at 5:04 PM telephone call was made

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FORM APPROVED Agency for Health Care Administration (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED A. BUILDING: R-C

		111356	B. WING		11/02/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE	
CORALB	EEF SUBACUTE CARE O	9869 SW	152ND STREET	r .	
CORMER	EET SOBACOTE CARE C	MIAMI, FI	L 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
{N 204}	Continued From page		{N 204}		de production de la constitución
	complaining of so mu to clarify if she had ca Resident #1 had calle that Resident #1 was police. Staff C stated: Staff C LPN explaine	d the police, staff C stated the one who called the "He did call the police!" d; the police was called to n down while she helped			
	Class I			77,000	data vana data parta da
(N 216) SS=J	In addition to the grou chapter 408, any of the be grounds for action licensee: (1) An intentional or n	n and Safety of Resident unds listed in part II of he following conditions shall by the agency against a legligent act materially safety of residents of the	{N 216}		
	Based on records rev facility failed to ensum monitoring and super resident (Resident #1 residents of the 17 R medications a received failed to effectively m Resident #1's diagnor and multiple episodes lead to Resident #1 s #1 while unsupervise	vision was provided for one		N216  Corrective action: Resident #1 no longer resides in the facility Nursing Staff involved with Resident # care were educated to effectively mon behaviors related to diagnosis of and  Identification of other residents with potential to be affected: Residents with a diagnosis of have the potential to be	

AHCA Form 3020-0001

STATE FORM cesso ET8W12 If continuation sheet 29 of 35

PRINTED: 11/30/2021 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: P.C B MING 111356 11/02/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9869 SW 152ND STREET CORAL REEF SUBACUTE CARE CENTER LLC MIAMI, FL 33157 (X433F) SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (N 216) Continued From page 29 (N 216) The Findings Included: affected Residents who have a diagnosis of Record review of the facility's policy and and ..., were audited to ensure procedures titled, "Safety and Supervision of behavior sheets are in place to identify Residents," Revised in ...... revealed the behaviors, interventions placed to policy statement: Our facility strives to make the intervene with the behaviors and referrals environment as free from accident hazards as made for .... and mental health possible. Residents' safety and supervision and evaluations. assistance to prevent accidents are facility wide Measures/Systematic Changes made to commitment to safety at all levels of the ensure non-reoccurrence: organization. Policies titled Accident & Incident-Facility oriented approach to safety included: investigation and Reporting and "Employees shall be trained on potential hazards Behavioral Health services. and demonstrate competency on how to identify Informed Care and -Clinical and report accident hazards and try to prevent Protocol were reviewed avoidable accidents. Individualized, The Administrator/designee educated resident-centered approach to safety included: Licensed Nurses, Certified Nursing Aides 1. Our individualized, resident centered approach and Social Services regarding behavioral to safety addresses safety and accident hazards health with emphasis on effectively for individual residents, 2. The interdisciplinary monitoring residents with

..... diagnosis and to ensure

Social services and nursing staff were

newly added questionnaire regarding

behavioral health with emphasis on

., ... diagnosis and to ensure

referrals are made for mental health

care will be educated to all new hires

assessment and behavior Monitoring

during orientation by the DON/designee

New admissions will be reviewed during

Informed Care

monitoring residents with

evaluations. In addition.

clinical meeting for

educated by the Administrator/designee

Newly hired staff will be educated by the DON/designee during orientation on

informed care including a

referrals are made for mental health

evaluations

ดก

care team shall analyze information obtained

any specific accidents hazards or risks for

from assessments and observations to identify

individual residents, 3. The care team shall target

interventions to reduce individual risks related to

hazards in the environment, including adequate

approach to safety noted: 2. Resident supervision is a core of the systems approach to safety.

· "Resident

supervision and assistive devices. Systems

Review of the care plans for Resident #1

# 1 exhibited behaviors of ...../agitation.

appropriate response to situations by next review

date." Approaches included, determine cause of

..., observe for changes in mental status.

of changes as needed. Further review of the care

plans showed that Resident #1 had diagnoses of

., and behavior, notify MD (Medical Doctor)

Goals: Resident #1 will be able to display

revealed, care plan dated

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11/02/2021

Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R-C

NAME OF PROVIDER OR SUPPLIER

B. WING \_\_\_ STREET ADDRESS, CITY, STATE, ZIP CODE

111356

NAME OF P	ROVIDER OR SUPPLIER	STREET ADDI	RESS, CITY, STA	ATE, ZIP CODE		
00041.0	EEF SUBACUTE CARE CENTER LLC	9869 SW 152ND STREET				
CURALR	EEF SUBACUTE CARE CENTER LLC	MIAMI, FL 33157				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FI REGULATORY OR LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
(N 216)	Continued From page 30		{N 216}			
	Resident #1 had a total of 9 episodes of Afraid/Panic. Five out of nine different episocourred during the hours of 7:00 AM to 7:00 nm 17, 20, and 25. Four differe episodes of Afraid/Panic occurred between hours of 7:00 PM to 7:00 AM, on and 28. The documented interventions for eepisode noted "Routine." Review of the nurses' progress notes for showed on record that addressed any the episodes of exhibited by Resider Review of the behavior sheets for	of forced.  # 1 2.  # 1 2.  The that to the that to the that the the that the the the the the the the the the th		sheet as indicated per diagnosis of and and referrals to behavioral health will be initiated as required Monitoring of Corrective Action: The DDN/designee will audit residents with a diagnosis of and to ensure behavior monitoring sheets accurately reflect resident's behaviors weekly X4 then Monthly x3 Social Services/designee will audit newly admitted residents for informed screen weekly X4 monthly X3. The DDN/designee and Social Services/Designee will present the results of the audits to the QAPI committee for review and feedback. Responsible party: DDN/Designee and Social Services/Designee		

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11/02/2021

Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R-C

111356

B. WING \_\_\_\_\_

NAME OF PR	OVIDER OR SUPPLIER	STREET ADDI	RESS, CITY, STA	TE, ZIP CODE	
CORAL REEF SUBACUTE CARE CENTER LLC 9869 SW 152ND STREET MIAMI, FL 33157					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUI REGULATORY OR LSC IDENTIFYING INFORMATIC		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	Continued From page 31  for showed that Resident #1 ha different piscles of Afraid/Panic during the PM to 7:00 AM shift. The Afraid/Panic behavi noted to have occurred on 9, 9:10, 1 51, 61, 71, 81, 92, 23, 24, 25 and 29. Re of the nurses' progress notes for showed no recorded documentation that addressed any of the afraid/panic episodes exhibited by Resident #1's behavior sheets for (initiated on ) showed no recorded documentation that addressed any of the afraid/panic episodes exhibited by Resident #1's behavior sheets for (initiated on ) showed Resident #1 had a total of 17 differe episodes of Afraid / Panic during the month o Four out 17 different episodes o Afraid/Panic occurred between 7:00 AM to 7 PM on 3, 4, and 5. The interver documented noted "Routine CHS (nightly at bedtime)". Further review of behavior montioning record showed that Resi #1 had 13 out of 17 different episodes of Afraid/Panic during the evening shift (7:00 PK 7:00 AM) on 7, 12, 13, 14, 17, 20, 21, 24, 26, 27 and 28. The documented intervention noted. "Refer to Nurses Notes:" Review of Nurses Notes for showed on recorded documentation that addressed the episodes of afraid/panic exhib by Resident #1.  Review of the behavior monitoring shed tate showed no recorded documentation that addressed the episodes of afraid/panic exhib by Resident #1.  Review of the behavior monitoring shed tate showed no recorded documentation that addressed the spisodes of afraid/panic between 7:0 PM to 7:00 AM on Reside #1 had two episodes of the Afraid/Panic between #1 had two episodes of the Afraid/Panic on the first had two episodes of the Afraid/Panic on the first had two episodes of the Afraid/Panic on the occurred during the day shift (7:00 AM to 7:0 and on the day of his Intervention for each episode noted "Routine OHS(EVERY) hour of the episode noted "Routine OHS(EVERY	7-00 cores on the cores of the	(N 216)		

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Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R-C 111356 B. WING \_\_\_\_ 11/02/2021

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ORAL REEF SUBACUTE CARE CENTER LLC 9869 SW 152ND STREET MIAMI, FL 33157						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE		
(N 216)	Continued From page 32	{N 216}				
(N 216)	Continued From page 32 sleep]." Review of the progress notes for , showed no recorded documentation that addressed any of the episodes exhibited by Resident #1.  Review of the nurses progress notes dated at 11:00 PM documented by Licensed Practical Nurse (LPN) staff C reveated." Resident assigned CNA [Certified Nursing Assistant] was observed running over to me while I was doing my med pass as he verbalized code blue, I immediately assigned a staff member to call 911 immediately assigned a staff member to call 911 immediately assigned a staff member to to the staff member to get the crash cart. I ran to his room. The residents skin color was noted as pale color, no, was noted resident was transferred from wheelchair to the bed. Board was placed under the patient and [	(N 216)				
	he found the patient. Family was notified by police. Police officer spoke to [ Emergency Contact]. The medical examiner arrived and transferred residents' body out of the facility."					
	Review of the investigative report and interview with the Clinical Regional Nurse on at approximately 2:30 PM revealed, the Clinical regional nurse had reviewed the facility's video			radioade para de la compansión de la compa		

AHCA Form 3020-0001

Agency for Health Care Adminis	tration		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	111356	B. WING	R-C 11/02/2021

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
CORAL REEF SUBACUTE CARE CENTER LLC 9869 SW 152ND STREET MIAMI, FL 33157							
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PF	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE		
{N 216}	Continued From page 33	{N 2	16}		-		
	recording as she investigated the event. The Clinical Regional Nurse documented her observation of the video and reported that she reviewed the video recording on "Tuesday or Thursday last week." The report noted that on Saturday 2:54 PM Resident #11 SCNA, (Staff A) went into the residents' room [room #] at 4:18 PM. Nurse (Staff B) was passis meds. The Clinical Regional Nurse stated: "You can see her going in and out of rooms." At 4:30 PM the friend (Resident #4) leaves Resident #4 is room. His door enabled to the resident for the friend (Resident #4) favore. His door emained open the whole time. At 5:21 PM the Nurse (Staff B) went into Resident #1's room. However the Nurse (Staff B) went into Resident #1's room. At 5:43 PM the CNA (Staff A) picked up the tray, (Noted that he ate 100%). At 6:25 PM it appeal the door is shut from inside the room. No one checked on the resident or attempted to enter the room from approximately 6:25 PM to 8:15 PM (Staff C) LPN was scheduled to start her shift at 7:00 PM, no indication that she checked on Resident #1 from the time her shift started until the CNA called her at around 8:15 PM. At 8:15 PM. At 8:15 PM. the CNA tried to get into the room for a few second, leaves the area gets the door, is three to get into the room and note that the door was closed. The CNA tried to get the door, but the sold that the cash call. The Regional mess explained that the Crash call. The Regional research was not get a set of the proper second that the pulled the bag off Resident #1's seated in his wheelchair, unresponsive with a bag over his . The CNA staff was in the room for a few second, leaves the area gets the sex part of the proper sex parts of the proper s	u d d d d d d d d d d d d d d d d d d d					

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STATE FORM 6550 ET8W12 If continuation sheet 34 of 35

PRINTED: 11/30/2021 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_\_ P.C B. WING 111356 11/02/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9869 SW 152ND STREET CORAL REEF SUBACUTE CARE CENTER LLC MIAMI, FL 33157 (X433F) SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (N 216) {N 216} Continued From page 34 Residents body was transferred to the Medical Examiner's office. During an interview on at 10:56 AM the Psychiatrist reported he did not review the above mentioned behavior monitoring sheets in Resident #1's clinical\_record. The Psychiatrist explained that he met with the facility's staff and discussed residents' behaviors and if any adjustments are needed. When asked about Resident #1, the Psychiatrist reported he was not aware that Resident # 1 had any behaviors. Upon discussion of the multiple documented episodes of afraid/panic noted on Resident #1's clinical record, the Psychiatrist reported he was not aware and that the nurses had not communicated the behaviors to him. The Psychiatrist explained that the facility staff should have communicated ..., afraid/panic episodes and any other behavior exhibited by Resident#1 to him, "If they tell me I would definitely do something. The nurses usually call me. They did not tell me about those episodes. Had I known, I would have definitely done something, I would have gone to see him, maybe change the medication ..." Class I

		ID HUMAN SERVICES				FOR	M APPROVED		
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(MOV NACE)	TIEV I	E CONSTRUCTION		D. 0938-0391		
		IDENTIFICATION NUMBER:	A. BUILD				(X3) DATE SURVEY COMPLETED		
			rt. Boile			6	R-C		
		105910	B. WING				/02/2021		
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		OLILOL		
				4	9869 SW 152ND STREET				
CORAL R	CORAL REEF SUBACUTE CARE CENTER LLC			,	MIAMI, FL 33157				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	1D	_	PROVIDER'S PLAN OF CORRECTION	N	(X5)		
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	COMPLETION DATE		
{F 000}	INITIAL COMMENTS	;	{F (	000)					
		vey for complaint numbers							
		1013886,was conducted on							
	Coral Reef Subacute	rough , , at							
		aint number 2021013844							
		thout deficient practice. The							
		aint number 2021013886							
	was substantiated will	th deficient practice. The							
		npliance with 42 CFR 483,							
	Requirements for Lor	ng Term Care Facilities.							
	On .	, it was determined the							
		posed immediate jeopardy							
		ety of the residents admitted							
	to the facility.	•							
	Immediate Jeopardy	means, a situation in which							
	immediate corrective						}		
		's noncompliance with one							
	or more requirements								
	to cause, serious inju	ation has caused, or is likely rv, harm, , , , or							
		ry, narm, , , , or f receiving care in a facility.							
	10 0/1 // (1000)	, racarring out on a tacking.							
	The Immediate Jeopa	ardy started on ,							
	The facility's Administ	trator, Director of Nursing							
		Consultant were notified of							
	the immediate Jeopa								
		nediate Jeopardy templates							
	were provided.								
	Immediate Jeonardu	and Substandard Quality of							
	Care was identified a								
		verity (J) - Freedom from							
	and Neglect						-		
	E 656 Scone and Se	verity (.i) - Development and					(		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed

(X6) DATE /2021

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.

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/30/2021

DEFAILI	MENT OF HEALTH AN	ID HOMMIN SERVICES				FORM	APPROVED.	
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0.0938-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING				(X3) DATE SURVEY COMPLETED	
		105910	B. WING				-C 02/2021	
NAME OF P	ROVIDER OR SUPPLIER			٤	STREET ADDRESS, CITY, STATE, ZIP CODE			
				g	869 SW 152ND STREET			
CORAL R	EEF SUBACUTE CARE (	GENTER LLC		n	MIAMI, FL 33157			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
{F 000}	Implementation of Ca	re Plans verity (J) - Free of Accident	{F C	00}				
	132.	the time of the survey was						
	was submitted on	ate Jeopardy removal plan						
	Removal Plan was ve through record review	cility's Immediate Jeopardy riffied by the survey team vs and interviews. It was lity completed in-services for related to the Immediate s.						
	of the facility's correc							
	689 were lowered to	ity for F 600, F 656 and F a (D) for No actual harm with aan minimal harm that is not as of						

The following is a description of the

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/30/2021

DEFAIL	WENT OF HEALTHAN	ID HOWAIN SERVICES				FORM	M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0.0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		105910	B. WING			1	I-C 102/2021
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				98	69 SW 152ND STREET		
CORAL R	EEF SUBACUTE CARE (	CENTER LLC		M	IAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
(F 600) SS≃D	Free from and CFR(s): 483.12(a)(1)	Neglect	{F 6	00}			
	and includes but is not lir corporal punishment, any physical or chem treat the resident's m \$483.12(a) The facilit \$483.12(a)(1) Not us	right to be free from tition of resident property, effined in this subpart. This ititled to freedom from involuntary and ical not required to edical symptoms.  y must- e verbal, mental, or					
	Removal Plan was ve through record review	cility's Immediate Jeopardy erified by the survey team as and interviews. It was lity completed in-services for					

related to the Immediate

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/30/2021

OCHTED	o FOR MEDICARE	MEDICALD OFFICE				M APPROVED
		MEDICAID SERVICES				O. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	CONSTRUCTION	COM	E SURVEY IPLETED
		105910	B. WING			R-C 1/02/2021
NAME OF P	ROVIDER OR SUPPLIER	•	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
CORAL R	EEF SUBACUTE CARE (	CENTER LLC	1	69 SW 152ND STREET		
			Mi	IAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
{F 600}	Jeopardy deficiencies The scope and sever of the facility's correc The immediate jeopa removed on The scope and sever to a (D) for No actual more than minimal ha jeopardy as of The Findings Include Record review of the pooles and services in media and behavior or or neglect Record review of the procedures revealed Medical of Policy noted; any drug that affects with process and beh Nurse Practitioner) w Medication appropri-	ity was lowered as a result to was clowered as a result to was actions implemented. The was determined to be the form of the property of the was determined to be the was determined to the w	{F 600}			

Standards included:

### PRINTED: 11/30/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES ST

DEPARTMENT OF HEALTH AN	DEPARTMENT OF HEALTH AND HUMAN SERVICES					
CENTERS FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391		
AND DI AN OF CORRECTION IDENTIFICATION NUMBER		(X2) MUL' A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
	105910	B. WING		R-C 11/02/2021		
NAME OF PROVIDER OR SUPPLIER	133313		STREET ADDRESS, CITY, STATE, ZIP CODE	11/02/2021		

9869 SW 152ND STREET

CORAL R	EEF SUBACUTE CARE CENTER LLC		9869 SW 152ND STREET				
			L	MIAMI, FL 33157			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY PILL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 4  C. The facility supports the goal of determining the underlying cause of behavioral symptoms so the appropriate treatment of environmental, medical and /or behavioral interventions, as well as psychopharmacological medications can be underlying the the needs of individual resident.  G. Psychopharmacological medications will be used to enhance the quality of life for the resident and will never be used for the purpose of discipline or convenience.  Procedures followed by the Primary Care Physician, PA[Physician's Assistant], or NP [Nurse Practitioner] noted: 2. Documents rationale and diagnosis of the use and identifies target symptoms. 4. Evaluates with the interdisciplinary team, effects, and side effects of medications within 14 days of initiating, increasing, or decreasing dose and during routine visits thereafter. Procedures Followed by the Psychiatrist / mental health included: item 1 indicated— assist the facility in establishing appropriate guidelines for use, dosage and monitoring of, medications. Item number 5 indicated— Help develop behavior management plans.  Procedures Followed by Nursing:  1. Monitors, drug use daily, noting any adverse effects such as increased somnolence or functional decline.  2. Will monitor for the presence of target behaviors on a daily basis. Behaviors will be documented as warranted.	PREFI		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION		
	Reviews the use of the medication with the physician and the interdisciplinary team on a quarterly basis to determine the continued presence of target behavior and or the presence						
	of any adverse effects of the medication use. 4. [						

		ID HUMAN SERVICES MEDICAID SERVICES					M APPROVED
	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(V2) MOI	TIO	LE CONSTRUCTION	(X3) DATE	D. 0938-0391
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD				PLETED
						R	-C
		105910	B. WING	_		11/	02/2021
NAME OF P	ROVIDER OR SUPPLIER			Г	STREET ADDRESS, CITY, STATE, ZIP CODE		
CORAL R	EEF SUBACUTE CARE O	CENTER LLC			9869 SW 152ND STREET		
				L	MIAMI, FL 33157		·
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD IS CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 600}	will be performed on a		{F €	600	)		
	will be reported to the 5. develop behavindividualized non-ph	physician. vioral care plans that include armacological interventions. urdinates the interdisciplinary					
	revealed, he was adn	diagnoses included but were and					
	and Treatment Recommedication included:  1 mg (m tablet to be given by diagnosis of 50 mg tab given by every diagnosis of 5 milligrar	elet ordered 1 tablet to be					
	Data Set (MDS) and it coordinator, Staff H o AM revealed, Resider facility on comprehensive MDS, a score of 15 on the	, dated . He had					

was able to verbalize his needs and was not

		ID HUMAN SERVICES					M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		PLETED
		105910	B. WING				-C 02/2021
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				9	869 SW 152ND STREET		
CORAL R	EEF SUBACUTE CARE O	ENTERLLC		N	MAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
(F 600)	revealed that Resider pattern and was able as make self-underst included and include the diagnosis. Review of the care pli revealed a care plan #1 exhibited behavior. Resident #1 will be at response to situations Approaches included Observe for and behavior, to of changes as needed plans showed that Rejand was a pattern. Approaches ichanges in en feelings, administer There were no care py or for the proposition of the proposition of changes in endication of the proposition of the pro	Further review of the MDS at #1 had a clear speech to understand others as well book. His active diagnoses (, ), but the MDS did not of as as for Resident #1 dated ;"Resident s of /sgitation. Goals: ble to display appropriate be to display appropriate by the review date." determine cause of changes in mental status, solidity MD [Medical Doctor] d. Further review of the care sident #1 had diagnoses of at risk for alterations in noticed, observe for as ordered. lans for the diagnoses of the use of 5 mg didn't #1's Behavior the months of indicated that initored for the behaviors to the use of 1 as no record to indicate that	{F + 6	600}			

records showed no records to indicate that he was monitored for his diagnosis of . . , . . . . or

Facility ID: 111356

		ID HUWAN SERVICES					M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	D. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	COMP	SURVEY PLETED
		105910	B. WING			1	R-C /02/2021
NAME OF P	ROVIDER OR SUPPLIER			81	FREET ADDRESS, CITY, STATE, ZIP CODE		
	EEF SUBACUTE CARE (	THE LLO		98	869 SW 152ND STREET		
CORAL K	EEF SUBACUTE CARE	JENIER ELC		М	IAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
(F 600)	for the use of the mg tablet. Further review of Beh showed the resident in documented as "Afra of (Initiated had a total of 9 episo of nine different epischours of 7:00 AM to 7 20, and 25. Four diff Afraid/Panic occurred AM, on each episode noted facility's only interven of his routine medicat tablet by at be a constant of the form to recorded documental the episodes of Review of behavior m to recorded documental the episodes of Review of behavior and was left blank for during the day shift (Initiated on and was left blank for during the day shift (Todoumented behavior monitored during that behavior monitoring of revealed Resident #1 4 Afraid/Panic during the 17:00 AM). The Afraid/Panic during the Review of Viurses Preview of Nurses Preview	savior Monitoring Sheets and multiple episodes and provides and	{₽=€	600}			

episodes of afraid/panic exhibited by Resident #1.

### PRINTED: 11/30/2021 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES STA

CENTERS FOR MEDICARE &	MEDICAID SERVICES		OMB NO. 0938-039					
AND DI AN OF CORDECTION DENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED					
			R-C					
	105910	B. WING	11/02/2021					
ALMARE OF PROVIDED OR CURRULED		CTDEET ADODESS CITY STATE 7ID CODE						

		105910	D. WING_			11/	02/2021
NAME OF PE	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
			- 1	9	869 SW 152ND STREET		
CORAL RI	EF SUBACUTE CARE O	ENTER LLC	- 1				
				IV	NAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)		(X5) COMPLETION DATE
{F 600}	Continued From page	8	{F 60	00}			
( 333	Review of behavior m for F resident continued to for I resident continued for I resident episodes du filler occurred for I resident episodes for I resident episode for I resident for I residen	conitoring sheets for Resident #1 showed the be monitored for episodes iddent #1 had not total of 17 ring the month of 17 different episodes of between 7:00 AM to 7:00 3, and 5. The intervention every night at bedtime) lifty's only intervention was its routine medication, left 1 tablet by at the second of the	(1-00	00}			
	7:00 PM to 7:00 AM on . The interventions for each episode noted "Routine QHS." indicating that the facility's only intervention was the administration of his routine medication; 1 mg tablet by . at						

Facility ID: 111356

		ID HUMAN SERVICES					M APPROVED
		MEDICAID SERVICES					0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		CONSTRUCTION		PLETED
		105910	B. WING				t-C (02/2021
NAME OF PE	ROVIDER OR SUPPLIER	•		S'	TREET ADDRESS, CITY, STATE, ZIP CODE		
				98	869 SW 152ND STREET		
CORAL RI	EEF SUBACUTE CARE (	CENTER LLC		м	NAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 600}	Continued From page bedtime.	9 9	{F (	300}			
	Review of the progres showed no record that episodes exhibited by	at addressed the afraid/panic					
	with time	rses progress notes dated noted as 11:00 PM Staff C revealed: "Resident					
	assigned CNA [Certification observed running over	ied Nursing Assistant] was er to me while I was doing					
	my med pass as he v immediately assigned						
	another staff member	orillator machine. I assigned to get the crash cart. I ran					
	as pale color,	dents skin color was noted no , was noted resident					
	board was placed une						
	{ 911 arrived and EMT						
		the time of CNA					
	unable to enter his ro	ent verbalized that he was om. The CNA stated he had					
	resident wheelchair w	open the door. CNA stated vas pushed against the door					
	was noted over his	the wheelchair. Trash bag CNA stated he removed					
	Patient was not breat	f patient was not breathing. hing per CNA statement.					
	he found the patient.	to me and to the police how Family was notified by					
	police. Police officer s	spoke to [Emergency Il examiner arrived and					
		body out of the facility."					
	Review of the investig	gative report and interview					

DEPART	FORM	APPROVED					
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '		ECONSTRUCTION	1	SURVEY LETED
		105910	B. WING _				02/2021
NAME OF PR	ROVIDER OR SUPPLIER			5	TREET ADDRESS, CITY, STATE, ZIP CODE		
CORAL RI	EF SUBACUTE CARE O	CENTER LLC			869 SW 152ND STREET MAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFID TAG				(X5) COMPLETION DATE
{F 600}	nurse reviewed the fa she investigated the e observations of the vi Nurse reported that s recording on "Tuesda The investigative rep at 2:54 PM Nursing Assistant (Ch residents' room [room B), Registered Nurse	on 10  M revealed, the regional cility's video recording as swent. She documented her deo. The Clinical Regional he reviewed the video yor Thursday last week." ort noted that on Saturday Resident #1's Certified Aly (Staff A) went into the #1 at 4:18 Ph. Nurse (Staff (RN)was passing meds, gip and out of fooms." At	{F 60	200}			

backboard placed, and .

4:30 PM the friend (Resident #4) leaves Resident #1's room. The video showed that at 4:52 PM meal was delivered to Resident #1's room. His Door remained open the whole time. At 5:21 PM the Nurse (Staff B) went into Resident #1's room. At 5:43 PM the CNA [Staff A] picked up the tray. Noted that he ate 100%, At 6:25 PM it appears the door is shut from inside the room. No one checked on the resident or attempted to enter the room from approximately 6:25 PM to 8:15 PM (Staff C, LPN) was scheduled to start her shift at 7:00 PM, no indication that she checked on Resident #1 until the CNA called her at around 8:15 PM. At 8:15 PM the CNA tried to get into the room and noted that the door was closed. The CNA tried to open the door, but it was blocked. (Staff A) was in the room for a few second, leaves the area gets the nurse and the crash cart... The Regional nurse explained that the CNA had to push the door open and when he entered, he noted Resident #1 seated in his wheelchair. unresponsive with a bag over his

stated that he pulled the bag off Resident #1 and ran to get help. A code was called as well as 911, staff responded to this resident's room where they transferred him to the bed, a

Facility ID: 111356

. The CNA

initiated. Law

		ID HUMAN SERVICES						APPROVED
		MEDICAID SERVICES						0938-0391
	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		CONSTRUCTION		(X3) DATE S COMPL	ETED
		105910	B. WING				R-4	2/2021
NAME OF P	ROVIDER OR SUPPLIER			STE	REET ADDRESS, CITY, STATE, ZIP CODE			
				986	9 SW 152ND STREET			
CORAL R	EEF SUBACUTE CARE (	CENTER LLC		Mil	AMI, FL 33157			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE		(X5) COMPLETION DATE
{F 600}	enforcement and EM thereafter and pronou		{F €	600}				
	Certified Nursing Ass worked in the facility-floated on different ur care of Resident #1c C Saturday ( CNA explained that F the Bed B at the wind was empty. Staff A, C #1 was alert and liked with the door closed, go to the bathroom at isolation precautions, schedule for that wee he worke AM -3:00 PM and fror continued on Saturda from 7:30 AM to 11:3 the day of the incider from my break which when I came an onticed that the door one of the CNAs. He door. I thought he mig with something. Whe noticed the resident y plastic bag over his locked. He normally to en each side of inside of it. Once I op lastic bag on his	at 3.53 PM with Staff A, istant (CNA) revealed, he for about one year and lits every week. He took in Friday, () and ), when he Staff A, tesident #1 was assigned to low and Bed A by the door NA reported that Resident et at the stay in his room alone He required assistance to not remained in his room on Staff A, CNA revealed his kend was on Friday, d a double shift from 7:00 m 3:00 PM to 11:30 PM. He by to again work of PM to 8:30 PM of Was doling his from 8:00 PM to 8:30 PM, d was doing my rounds and would not open. I spoke to recommended; I pushed the ght have blocked the door In finally opened the door, I vas sitting in his chair with a The wheelchair was lad two trash containers, is bed, with plastic bag ened the door, I notice the I took the plastic bag; In direct for hot. The floor in cred the foor, I notice the I took the plastic bag; In direct for help. The floor						

nurse was on the hallway. We went to get the

		ID HUMAN SERVICES MEDICAID SERVICES					MAPPROVED 0. 0938-0391
TATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		LE CONSTRUCTION	(X3) DATE COMP	
		105910	B. WING	_		11/	02/2021
	ROVIDER OR SUPPLIER SEF SUBACUTE CARE O	CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 9869 SW 152ND STREET MIAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 600}	transferred the reside initiated the The ambulance arrived. T interviewed me. I confer the detective intexplained that sometic aggressive and had be such as he refused a shave and Staff A coro allowed Staff A to sha that long ago, maybe would sometimes get one time, he took off lodd the nurse on the asked her to come to translate. I explained here to take care of h	code blue. The nurse and Int from the wheelchair, they ay all continued until the police arrived they all continued until the he police arrived they all continued until the service of the facility until arviewed me." Staff A, CNA mes Resident #1 was ehawiors like refusing care haircut and refused to winced Resident #1 and ve him. Staff A added "not two weeks". [Resident #1] angry and yell at staff; "like his gown and threw at me, I floor about the behavior and the room and help me to [Resident #1] that I was lim, and that there was no a toward me, [Resident#1] as toward me, [Resident#1] toward me, [Resident#1] toward me, [Resident#1] toward me, [Resident#1]	{ <b>F</b> €	00	))		
	with the Director of N Clinical Regional Nur nurses on the floor us monitoring sheets. The monitor and documer would report each bel Behaviors that are un behaviors that are un behavior that might p such as . The dependa	se, the DON explained; The usually complete the behavior te nurses are the ones that it the behaviors, the CNA havior to the nurses. ported and documented are usual for the patient and any ut the patient in distress, plan of care for diagnoses do not necessary to a plan of care for diagnoses do not necessary to non a support for all staff. For onal support for all staff. For					

interested in. Encourage them to talk about their feelings. Encourage socialization. Provide

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				FORM	APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES					0. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIP	PLE CONSTRUCTION	(X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	iNG	3	COMP	PLETED
						R-	-C
		105910	B. WING	_		11/	02/2021
NAME OF PR	ROVIDER OR SUPPLIER			Г	STREET ADDRESS, CITY, STATE, ZIP CODE		
CODAL DI	EEF SUBACUTE CARE O	CENTED II C		1	9869 SW 152ND STREET		
CORAL RI	SEF SUBACUTE CARE C	SENTER LLC		1	MIAMI, FL 33157		
(X4) ID		ATEMENT OF DEFICIENCIES	1D		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE
TAG	REGULATURE ON I	SCIDENTIFTING INFORMATION;	TAG		DEFICIENCY)	UE	
			-	_			$\vdash$
{F 600}	Ctinuad From page	- 40		-00			
(L cool	Continued From page		{F €	ou	J)		
		positive behaviors. Notify					
		of changes as needed.					
	Psych consult as nee						
		rdered. During the interview,					
	showed, Resident # 1	ident #1's clinical record					
		s physician orders  1 mg tablet, 1 tablet by					
	at bedtime for						
	50 mg tab						
	give 1 tat						
		nd Clinical Regional Nurse					
		sident #1's clinical record					
		of care that specifically					
	addressed his use of						
		Both the DON and					
		Nurse agreed there was no					
	care plan on record s	pecific to the use of the					
	, or	, medication and					
		ident on , , we					
	would normally use s	ame type of interventions as					
	with a resident that ha						
		thing we would do is monitor					
	for side effects, which						
	management. The us						
	monitor for						
		ident. We have residents					
	that are verbally able						
		look at signs or symptoms.					
		ors on the behavior sheet,					
		that occurs and on the daily					
	skill nurses' notes. W	nen it comes to the					
	include sleepiness, fa						
		." During the interview review of Resident #1's					
		ON explained; "We have					
	behavior monitoring s	meets for the use of					§

, it shows that we monitor for behaviors "Fear/Panic, . . . , kind of stuff." According to

		ID HUMAN SERVICES MEDICAID SERVICES					APPROVED 0. 0938-0391
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		PLE CONSTRUCTION 3	(X3) DATE COMP	
		105910	B. WING			11/	02/2021
NAME OF P	ROVIDER OR SUPPLIER	•	•	Г	STREET ADDRESS, CITY, STATE, ZIP CODE		
CODAL D	EEF SUBACUTE CARE O	CENTED LLC			9869 SW 152ND STREET		
CORAL R	EEF SUBACUTE CARE C	SENTER LLC			MIAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 600}	, ,	tation on the Behavior	{F (	300	0}		
	episodes." The DON general staff reported	explained: "The nurses and that the resident was ver his health. He did not like					
	the . He did to	alk about it sometimes. He and 2nd. The only					
	on the Behavior Moni have a behavior moni	medication as documented toring SheetsWe do not itoring record for the use of					
	Regional Nurse both residents record for a						
	were no actual writter	ors and acknowledged there n notes that addressed any					
	of the resident's beha DON and the Clinical such documentation	Nurse Manager agreed					
		05 PM, during an interview ined that Resident #1 gave					
	facility staff was "usua	was depressed, and that the ally very good at letting us ny indication, not only					
	present, but also past clinical , T	t history, or any indication of hey usually call me for an					
	taking ,	t of the patients that are , they usually generate a patient had shown any signs					
	or symptoms, indicati	ng they had clinical , the staff would					
		#1 once, on and					
	Psychiatrist on	ed interview with the at 10:56 AM revealed,					
	the poughietrief did no	at rovious the	1				

above-mentioned Behavior Monitoring Sheets found in Resident #1's clinical record. The

		ID HUMAN SERVICES				APPROVED
		MEDICAID SERVICES		_		0.0938-0391
	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		LE CONSTRUCTION	LETED
		105910	B. WING	_		-C 02/2021
NAME OF P	ROVIDER OR SUPPLIER			-	STREET ADDRESS, CITY, STATE, ZIP CODE	
		THE LLO		,	9869 SW 152ND STREET	
CORAL R	EEF SUBACUTE CARE O	ENTERLLC		L	MIAMI, FL 33157	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
{F 600}	staff and discussed fr any adjustments are was asked about Res Psychiatrist reported Resident # 1 had any of multiple document noted on Resident #1 psychiatrist reported the documented behs nurses did not comm him. The psychiatrist should have commun afraid/panic episodes exhibited by Resident would definitlely do so usually call me. They episodes. Had I know.	I that he met with facility sident's behaviors and if needed. The Psychiatrist ident #1's behaviors. The he was not aware that behaviors. Upon discussion de episodes of afraid/panic 's clinical records the viors and stated that the unicate said behaviors to stated that the facility staff icated any and other behavior and other behavior and other behavior with the unicate said behaviors to stated that the facility staff icated any and other behavior #1 to him. "If they tell me I wmething. The nurses did not tell me about those m, I would have definitely id have gone to see him,	{F €	500]		
	Services assessment interview with the faci Social Services Direc Services Assistant (S that social services is the residents upon an annually. The SSD rethe residents upon an unually and behavior to the resident's room assessment on services note dated services will be available family for support if no	ility's Social Services Staff; tor (SSD) and Social SA), Staff F.; it was revealed responsible for assessing finission, quarterly, and vealed social services saw ound the facility, assess for of Mental Status) score, s. The SSD stated he went to complete the initial Review of the social				

little interest or pleasure in doing things,

		ID HUMAN SERVICES					M APPROVED
		MEDICAID SERVICES					0. 0938-0391
	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		E CONSTRUCTION	1	PLETED
		105910	B. WING	_			I-C 102/2021
NAME OF P	ROVIDER OR SUPPLIER			8	STREET ADDRESS, CITY, STATE, ZIP CODE		
		THE LLO		9	9869 SW 152ND STREET		
CURAL R	EEF SUBACUTE CARE (	SENTER LLC		1	MIAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 600}	frequency. 2 to 6 day or hopeless, frequency or having little energy Poor appetite or over days. The Social Ser followed the question Health Questionnaire interest / pleasure in depressed, or hopele asleep or sleeping to energy, feeling bad a ft's] assessment show was a six which had a symptom of fee he had poor appetite, and was feeling down news. The SSD report of the health	s. Feeling down depressed y, 2 to 6 days. Feeling tired, requency 7 to 11 days. eating, frequency 7 to 11 days. eating, frequency 7 to 11 days. eating, frequency 7 to 11 dives Director explained they naire on the form Patient (PHC-9) which asks about doing things, feeling down, ss, trouble falling /staying or much, if tired, feeling little bout yourself. (Resident weed the score result for his in indicated that the resident eight gired having low energy, little interests in doing stuff in the was upset about the ted he did not address hat he was feeling down, seident had diagnoses of at his medications. He was I saw that he was a patient that we en, very social, attended anything, I asked the depressed, he said it was was not much I could do aware of "The to reported they usually its concerning behaviors ngs and never knew that he hen asked why there was	₹₽-€	500}			

Staff B Registered Nurse (RN) reported working

DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES				FOR	MAPPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION		SURVEY
OND PIDON OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	š	1	
						F	t-C
		105910	B. WING	_		11)	02/2021
NAME OF PE	ROVIDER OR SUPPLIER			Г	STREET ADDRESS, CITY, STATE, ZIP CODE		
	EEF SUBACUTE CARE O	THE LLO			9869 SW 152ND STREET		
CORAL RI	EEF SUBACUTE CARE C	SENTER ELC			MIAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPT DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 600}	Continued From page	. 17	{F (	-00	01		
(i 000)	, ,		(1-6	JUC	u)		
		this year and normally					
		it #1) three days a week, PM, The resident was alert					
		ree. He communicated his					
		ally slept until about 9:00					
	AM/10:00 AM. He lik						
		d to come out of the room.					
		dent (Resident #1) was on					
		due to a _ ( ,					
		stated, " I worked from					
	Thursday,	, to Saturday					
		ehaviors related to his use					
		nonitored for					
		t remember him having any					
		nes would get a little upset					
		I that we closed the door,					
	close the window, or						
		it if the patient's behavior is					
		e was easily re-directed." not being present when					
		aggressive behavior of					
	throwing his gown at						
		r monitoring sheet for the					
		that I worked. I filled it out					
		the day that he					
	, What I	documented was that he					
	had one behavior of .						
		sking a lot about why he					
	remained with the trea						
		pt asking about it, although I					
	had already spoken to						
	intervention, during th						
		ason for the treatment, what					
	was the reason, and						
		mented on the behavior					
		out afraid/panic episode was					
	related to the	. creatment, that he	1				

received the treatment and that it was effective. I did not document on the nurses notes that the

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIENCLIA DENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETE  R-C  105910  STREET ADDRESS, CITY, STATE, ZIP CODE 9869 SW 152ND STREET (MAM, FL 33157  MAM, FL 33157  D PROVIDER SPLAN OF CORRECTION (RAC) (RAC			ID HUMAN SERVICES MEDICAID SERVICES					M APPROVED 0. 0938-0391
NAME OF PROVIDER OR SUPPLIER  CORAL REEF SUBACUTE CARE CENTER LLC    OAI ID   PREPRIX   (FLACH DEPTICIENCY MUST BE PRECEDED BY 17LL)   PREPRIX   (FLACH DEPTICIENCY MUST BE PRECEDED BY 17LL)   PREPRIX   (FLACH DEPTICIENCY MUST BE PRECEDED BY 17LL)   PREPRIX   PROVIDER'S PLAN OF CORRECTION   PRO	TATEMENT OF	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	A. BUILD			(X3) DATE COMP	SURVEY
CORAL REEF SUBACUTE CARE CENTER LLC    SUMMARY STATEMENT OF DEFICIENCIES   DISPERSIVE   PROVIDER'S PLAN OF CORRECTION   PREFIX   PRECIULATORY OR LIST DEPRITYING INFORMATION    PREFIX   TAG   PROVIDER'S PLAN OF CORRECTION   PREFIX   PRECIULATORY OR LIST DEPRITYING INFORMATION    PREFIX   TAG   CROSS-REFERENCED TO THE APPROPRIATE   CROS			105910	B. WING	_		11/	02/2021
CORAL REEF SUBACUTE CARE CENTRAL LC  DAILD  SUMMARY STATEMENT OF DEFICIENCIES  PREPIEZ  REGULATORY OR LSC IDENTIFYING INFORMATION)  (R-600)  Continued From page 18  resident was having an episode of, because I did my action, I did not see him to be desperate, he allowed me to administer his treatment. Sometimes with the elderly, they usually ask a lot about their treatment. The episode of, noted on him, was normal, expected. The purpose of the Behavior Monitoring Sheet is to follow for a prescribed, medication, and document the episodes related to the behavior, for which the resident is taking the medication. The intervention was 12 - Refer to nurses' notes." Staff B upon review of the records agreed there was no record to explain anything about the resident's or behavior. Staff B stated that: "It's established that a patient can have at least three small episodes of	NAME OF PRO	OVIDER OR SUPPLIER			Г	STREET ADDRESS, CITY, STATE, ZIP CODE		
MAM, FL 33157   MAM, FL 3315						9869 SW 152ND STREET		
FREENX TAG  REQULATORY OR LSC IDENTIFYING INFORMATION)  CONSTRUCTION OF THE APPROPRIATE  REQULATORY OR LSC IDENTIFYING INFORMATION)  CONSTRUCTION OR LSC IDENTIFYING INFORMATION)  FREGULATORY OR LSC IDENTIFYING INFORMATION)  FREGULATORY OR LSC IDENTIFYING INFORMATION)  FREGULATORY OR LSC IDENTIFYING INFORMATION  FREGULATORY OR LSC IDENTIFYING INFORMATION)  FREGULATORY OR LSC IDENTIFYING INFORMATION  FREGULATORY OR LSC IDENTIFY  FREGULATORY OR LSC IDENTIFYING INFORMATION  FREGULATORY OR LSC IDENTIFY  FREGULATORY OR LSC I	CORAL RE	EF SUBACUTE CARE C	ENTER LLC			MIAMI, FL 33157		
resident was having an episode of	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI	3E	(X5) COMPLETION DATE
we would document on the nurses' notes. The purpose of the behavior monitoring sheet is to see if the medication seems effective throughout the month. What the behavior monitoring sheet shows is that the medication is effective. I documented that he had		resident was having a because I did my active desperate, he allowed treatment. Sometimes usually ask a lot about episode of experted. The purpos Monitoring Sheet is to medication, a related to the behavior and the second side of experience of the records agreed that the records agreed that the records agreed that the records agreed that the month. What the I shows is that the medication the month. What the I shows is that the medication the month. What the I shows is that the medication the month what the month. What the I shows is that the medication the properties of the behavior on the second that the I show is that the medication that the month who was the shown in the second that the I show is that the medication that the month who was the shown or the second that the I show is the shown or or deall staff B add behavior on 24th, 25th, 25th, 15th. Whe did not report to anyone eded to communication the second that the I show is the shown on the shown or he was the shown or th	an episode of on, I did not see him to be on, I did not see him to be on, I did not see him to be on the did not see him to see him to see him to be on the did not see him to s	₹F €	600	3		

differently because are very dangerous, levels of in a person's

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

FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING \_\_ R-C

105910 B. WING 11/02/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

ORAL R	EEF SUBACUTE CARE CENTER LLC	- 1	9869 SW 152ND STREET MIAMI, FL 33157					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE				
(F 600)	Continued From page 19	{F 600}						
	can change and cause them to have a crisis. "	(						
	On that day he seemed well, he did not seem							
	depressed, he did not reject care, or complain of							
	." Upon discussion of Resident #1's							
	Diagnoses, Staff B, RN reported, "I am surprised							
	that he had a diagnosis of "When I							
	left on that day he remained in his bed, I went in							
	to see him at approximately 7:10 PM he was in							
	his room, he asked we close the door." Interview							
	with Regional Nurse and discussion of							
	surveillance video showed that staff B last saw							
	the resident at approximately 5:21 PM.							
	Record review revealed Resident #1 was under							
	the care of Staff C Licensed Practical Nurse							
	(LPN) one of the two times it was documented							
	that Resident #1 called the police because he							
	was in so much, ( ) and on the night							
	that he committed ( ).							
	On attempted to conduct a telephone							
	interview with Staff C, LPN on at							
	12:13 PM and a voice message was left. On							
	at 5:04 PM telephone call was made							
	again to interview Staff C. Staff C was interviewed							
	by phone and was asked that we call in 15							
	minutes. On at 5:08 PM an incoming							
	call was received from Staff C, she reported she							
	misdialed and requested we call her in 15							
	minutes. On at 5:24 PM, during a							
	telephone interview Staff C, LPN reported that							
	Resident #1 never had any complaints and "he							
	never had any , or , " when ask to							
	clarify her notes that the resident had , the call			-				
	was disconnected. During a follow up telephone							
	interview on at 7:20 AM, Staff C was							
	asked whether or not the resident ever expressed							
	or showed any signs or symptoms of			-				
	or while under her care. Staff C again			1				

PRINTED: 11/30/2021

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				FORM	M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION		PLETED
		105910	B. WING				-C 02/2021
NAME OF P	ROVIDER OR SUPPLIER			Π	STREET ADDRESS, CITY, STATE, ZIP CODE		
				l	9869 SW 152ND STREET		
CORAL R	EEF SUBACUTE CARE O	ENTER LLC			MIAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
(F 600)	reported, "no", when in handwritten nurses" in 12:00PM Staff C, sit had to call the police complaining of so mu to clarify if she had ce complaining of so mu to clarify if she had ce that had called the police she had called the	asked about her otes dated teated: "oh yeah, one time, I because he was cht." Staff C was asked alled the police or if Resident ce, staff C stated that one who called the police. I call the police! Staff C oblice was called to help on while she helped him. I plan included: a diagnosis of and teat to ensure they have an in conjunction with and procedures to identify pe in and behavior as did effectiveness of these rector of Nursing (DON) on a one-to-one basis ursing Staff, and Social shavioral health with ng residents prescribed medications and sk factors and changes in a well as side effects. serviced all staff on a rarding and Neglect. consultant will in-service a one-to-one basis consultant will in-service a one-to-one basis	₹F €	500	)		

informed care including a newly added

questionnaire regarding ......

		ID HUMAN SERVICES					M APPROVED
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	400 500	was de c			D. 0938-0391 E SURVEY
	DF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:			LE CONSTRUCTION		PLETED
			A. BUILU	MG	'	١,	R-C
		105910	B. WING				
ALLAND OF D	ROVIDER OR SUPPLIER	100010		_	STREET ADDRESS, CITY, STATE, ZIP CODE	1 11	/02/2021
NOUNE OF F	NOVIDEN ON SOFFEIEN			1	9869 SW 152ND STREET		
CORAL R	EEF SUBACUTE CARE O	CENTER LLC		1	MIAMI, FL 33157		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID.	_	PROVIDER'S PLAN OF CORRECTION	1	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	COMPLETION DATE
{F 600}	Continued From page	121	{F 6	รกก	11		
(,	Newly hired staff will I		, ,	,,,,	"		
		N/designee on monitoring					
	residents with diagno						
		nitor for behaviors related to					
	and	, and any noted side					
	effects of						
		informed care.					
		cted an audit of all active					
	residents with a diagr						
	, who are p						
		cation to ensure they have are in conjunction with					
		and procedures to identify					
	risk factors and chang						
		nd effectiveness of these					
	medication and to en	sure behavior monitoring					
	sheets are in place ar	nd reflect the behaviors of					
		side effects are monitored.					
		ill audit 100% of all active					
	residents with a diagr						
		ensure behavior sheets					
	reflect the resident's t	entions placed to intervene					
	with the behavior and						
		medications are					
		e collected weekly for a					
		or one quarter then monthly					
	for the next two quart						
	Services/designee wi	Il conduct informed					
	screening on all active	e residents.					
		s failure to develop and					
	implement a compreh						
		plan indicated: Residents					
	who are prescribed .						
	, medications v	vere audited to ensure a	1				1

care plan has been developed to effectively monitor for effectiveness and side effects of the

Facility ID: 111356

DDINITED: 11/30/2021

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE	SURVEY
WO FDW OF	OURNEUTION	EZENTI IOARION NOMBER.	A. BUILD	iNG	G		
		105910	B. WING				-C
		105910	D. WING	Ξ		11/	02/2021
NAME OF PE	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
CORAL RE	EF SUBACUTE CARE O	CENTER LLC			9869 SW 152ND STREET		
				L	MIAMI, FL 33157		,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD IS CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
(E COD)	0 " 1"		Ī				
{F 600}	Continued From page		{F €	500	.0}		
		escribed medication					
	to effectively manage	re a care plan is developed					
		one , ON educated facility staff on					
		cluding Licensed Nurses,					
	Certified Nursing Aide						
		n regarding residents who					
	are prescribed	, and					
	medications to effecti						
		nedication and side effects.					
		ADS) Corporate consultant					
		one In service with MDS					
		an In service with nursing					
	plan of care.	oping and implementing a					
	The Administrator/DC	N educated facility staff on					
		cluding Licensed Nursing					
		ng Aides on developing and					
		n for Residents who have					
		ively manage the Residents					
		S Corporate consultant will					
		Inservice with MDS staff					
		nservice with nursing staff and implementing a plan of					
	care.	and implementing a plan or					
	Newly hired staff will I	be educated by the					
		orientation on residents					
	who are prescribed	,					
	and , medication	medications to effectively					
		veness of the medication					
	and side effects.						
	An audit of all active r						
	and the second of the						
		sure a care plan has been					
		ely monitor for effectiveness					
	and side effects of the						
	Monitoring for Correc	RVE ACTION:					§

The DON or designee will audit 100% of all active

		ID HUMAN SERVICES MEDICAID SERVICES					M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		PLE CONSTRUCTION	(X3) DATE COME	SURVEY PLETED
		105910	B. WING	_		111	/02/2021
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
				ı	9869 SW 152ND STREET		
CORAL R	EEF SUBACUTE CARE O	CENTER LLC			MIAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(XS) COMPLETION DATE
(F 600)	and , medication v have been developed of the medications an Data will be collected twice a week for one-next two quarters.  Related to: Accident I believe the developed of the medication and accurately and etidentify and treat chause the developed of the devel	weekly to ensure care plans to monitor the effectiveness of monitor for side effects. weekly for a month then quarter then monthly for the Hazards, Supervision ride adequate supervision fectively monitored to nges in and so removal plan indicated: a diagnosis of an and tented to ensure behavior; on intervene with the lis made for alutations. No educated facility staff on cluding Licensed Nurses, as and Social Services health with emphasis on with and ure referrals are made for ions. Under the staff of the side of the	₹F €	600	0)		

are in place and reflect the behaviors of the resident and that referrals for mental health are

		ID HUMAN SERVICES MEDICAID SERVICES					M APPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		105910	B. WING				R-C /02/2021
	ROVIDER OR SUPPLIER	CENTER LLC		1	STREET ADDRESS, CITY, STATE, ZIP CODE 9869 SW 152ND STREET MIAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(XS) COMPLETION DATE
{F 600}	conducted as warran or designee will audit diagnosis of behavior monitoring a resident's behaviors. for a month then twic then monthly for the 1 Services/designee wi informed screening o The facility's removal onsite visit on interviews conducted Observations on residents with diagno and receiving m provided care and sea about the safety and were noted during ob about the safety and were noted during ob education and one to staff to ensure staff w knowledgeable. The 160 employees to staff to ensure staff w knowledgeable. The 160 employees to provide the behavior monitoring s Review of the Educat provided dated provided dated Documentation. Prog Detects. Monitor for	ted from the audit. The DON 100% of residents with a and to ensure heets accurately reflect Data will be collected weekly e a week for one quarter reset two quarters. Social il conduct the n all active residents.  plan was verified during an and telephone on revealed sampled sis of or addication were being rivices and no concerns well-being of the residents servations.  DO AM, the Nursing Home stated that she provided one training session to all erer fully trained and raining was provided to all lude the monitoring and ituation with residents defor, he correct information on the sheets.  In Monitoring, ress Notes and behavior Monitoring residents	(F e	600}			

		ID HUWAN SERVICES					FORM APPROVED		
CENTER	S FOR MEDICARE &	MEDICAID SERVICES					OMB NO. 0938-0391		
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		STRUCTION	(	X3) DATE SURVEY COMPLETED		
		105910	B. WING				R-C 11/02/2021		
NAME OF P	ROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE			_	
				9869 S	W 152ND STREET				
CORAL R	EEF SUBACUTE CARE (	SENTER LLC		MIAM	I, FL 33157				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETION E DATE		
(F 600)	medications effective Informed Care, behavior, and side ef factors and changes behavior, and side ef factors and changes to identify side effects , medicatio health evaluation. Camonitor for effectiven effects . Docume and following care provided feffectively manage the theoretic company of the factories of the in-service was provided of the Social Services Department of the factories of the fa	recis. Understand  fects. Able to identify risk in and behavior. Able is of and ins. Referral for mental re Plan:  to effectively ess of meds and side entation accuracy developing ans for residents who have levely manage their, and entify, -symptoms and e resident's. Review of clucation/in service dated by Corporate to the ant, Director of Nursing. ice logs dated to education was provided to in-service by the three staff members in Department, (3 staff from rtment), MDS and Care in-service was embers. On (1 aff). On et al. (1 aff). On et al. (1 aff). On et al. (1 aff). On the staff were side of the staff were lephone interviews on heat the inservices provided and that the inservices provided ind that the inservices provided and that the inservices provided and that the inservices provided and that the staff were able ling of the education	{₽ €	000}					

for residents who are on

, and medication and side effects

		ID HUMAN SERVICES MEDICAID SERVICES			FORM APPI OMB NO. 093	ROVED
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	DISTRUCTION	(X3) DATE SURVE COMPLETED	Υ
		105910	B. WING		R-C 11/02/20:	21
NAME OF PE	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CODE	1 1702120	
CORAL RI	EEF SUBACUTE CARE O	CENTER LLC	1	SW 152ND STREET MI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMP	X5) PLETION WATE
{F 600}	Continued From page of the medication.  Record review of the		{F 600}			
	Procedures: Coral Roman Neglect and Neglect and	eef Subacute Resident Policy s revised on al Assessment, Intervention				
{F 641} SS≖D	§483.20(g) Accuracy The assessment mus resident's status. This REQUIREMENT by: Based on record revi falled to ensure Minin assessments were ac resident (Resident #1 residents during a cor The Findings included Record review of Res Minimum Data Set (W. revealed; the assessr #1 returned to the fac "acute hospital." His Status () score the resident was speech, ability to und	of Assessments. It accurately reflect the Is not met as evidenced lew and interview, the facility num Data Set (MDS) courately coded for one ) out of ten sampled implaint investigation. It is ident #1's Comprehensive IDS) MDS dated ment showed that Resident illity on from Brief Interview of Mental was 15 out of 15, meaning	{F 641}			

from the hospital. He was . . . . of

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/30/2021 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES							0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL' A. BUILDI		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		105910	B. WING				-C 02/2021
NAME OF PE	ROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE		
CORAL RE	EEF SUBACUTE CARE O	ENTER LLC		1	9869 SW 152ND STREET MIAMI, FL 33157		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES [EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION]		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE
{F 641}	He had a plast month and also horior to admission. Senoted he used Section If Combined Section for the district of the combined Section for the district of the combined Section for the district of the distr	orior to admission within the ladd a two to six months section N for Medications , and for Active Diagnoses coded; and diastolic	{F 6	341]			
	Develop/Implement C CFR(s): 483.21(b)(1)	Comprehensive Care Plan	F	656	3		

§483.21(b) Comprehensive Care Plans

DDINITED: 11/30/2021

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO. 0938-039	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE COMP	SURVEY
						R	-C
		105910	B. WING			11/	02/2021
NAME OF P	ROVIDER OR SUPPLIER			8	TREET ADDRESS, CITY, STATE, ZIP CODE		
CORAL R	EEF SUBACUTE CARE O	CENTER LLC		1	869 SW 152ND STREET NAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	Continued From page	28	F	656			
, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		cility must develop and		000			
		nensive person-centered					
		sident, consistent with the					
		th at §483.10(c)(2) and					
	§483.10(c)(3), that in						
		ames to meet a resident's					
		mental and					
		ied in the comprehensive					
	assessment. The con	nprehensive care plan must					
	describe the following	j -					
	(i) The services that a	ere to be furnished to attain					
	or maintain the reside	ent's highest practicable					
		, . , well-being as					
		24, §483.25 or §483.40; and					
		would otherwise be required					
		25 or §483.40 but are not					
		esident's exercise of rights					
	under §483.10, includ						
	treatment under §483						
	(iii) Any specialized so	the nursing facility will					
	provide as a result of						
		a facility disagrees with the					
		RR, it must indicate its					
	rationale in the reside						
	( )In consultation with						
	resident's representat						
	(A) The resident's goa						
	desired outcomes.						
	(B) The resident's pre	ference and potential for					
	future discharge. Fac	ilities must document					
	whether the resident's	s desire to return to the					
	community was asset	ssed and any referrals to					
	local contact agencies	s and/or other appropriate					
	entities, for this purpo						
	(C) Discharge plans is	n the comprehensive care					

plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/30/2021

CENTED	C COD MCDICADE 8	MEDICAID SERVICES			OMB NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		105910	B. WING		R-C 11/02/2021
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COD	E
			ı	9869 SW 152ND STREET	
CORAL R	EEF SUBACUTE CARE (	CENTER LLC		MIAMI, FL 33157	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETION
F 656	by: Based on interviews reviewed, the facility an effective care plan treatments required b 10 sampled residents complaint investigatic develop a care plan to and did not deve addressed the Reside medications facility also failed to icare plan for diagnos by falling to e related to Resident # report episodes of Aff As a result of these of #1 sufficated himself bag over his report opisodes of Aff Section 10 to 1	is not met as evidenced  policy and records lailed to implement, develop for the quality of care and y one (Resident #1) out of reviewed during this in. The facility failed to a address Resident #1's topa care plan that and this use of and The mylement the Resident's es of and flectively monitor behaviors 1's diagnoses and failed to aid/Panic to the psychiatrist. efficient practices, Resident by placing a plastic trash sutling in his by it was determined the posed immediate jeopardy sty of all residents admitted cility's immediate Jeopardy with of all residents admitted cility's immediate Jeopardy with and in the provent of the providence of the related to the Immediate	F 65	5	

than minimal harm that is not immediate jeopardy

Facility ID: 111356

## PRINTED: 11/30/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES

POI						
CENTERS FOR MEDICARE & MEDICAID SERVICES			OMB NO. 0938-039			
ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
				R-C		
	105910	B. WING		11/02/2021		
IAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			

		105910	B. WING	_		11/4	02/2021
AME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
				١,	9869 SW 152ND STREET		
ORAL R	EEF SUBACUTE CARE O	ENTER LLC			MIAMI, FL 33157		
	OI BALL OVER	ATEMENT OF DEFICIENCIES		_	PROVIDER'S PLAN OF CORRECTION		
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFI	x	(EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIAT	Ę	DATE
					DEFICIENCY)		
			1				
F 656	Continued From page	30	F	656	3		
	as of						
	as 01						
	The Findings Included	4.					
	The Findings manuel	a.					
	Record review of the	Facility's policies and					
	procedures revised	titled; Care					
	Plans, Comprehensiv						
		atement, A comprehensive.					
	person-centered care						
		s and timetables to meet					
		and functional					
	needs is developed and implement						
	resident.						
	residera.						
	The Policy Interpretation and Implementation						
		ciplinary team in conjunction					
	with the resident and						
	representative develo						
		on -centered care plan for					
		care plan interventions are					
	derived from a thorou						
	information gathered						
	comprehensive asses						
	comprehensive asses	ioneni.					
	Review of the care plant	ane for Recident #1					
	revealed, a care plan						
	"Resident #1 exhibite						
		ils: Resident #1 will be able					
		response to situations by					
	next review date." Ap						
		, observe for changes					
	in mental status,	, and behavior, notify MD					
	(Medical Doctor) of ch						
		care plans showed that					
	Resident #1 had a dia						
	was at risk for alterati						
		observe for changes in					
		balization of feelings,					
	administer	as ordered. There					

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR MEDICARE & M	EDICAID SEDVICES				O. 0938-0391
	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE O	ANICTOLICTION		E SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	CINSTRUCTION	сом	PLETED
	105910	B. WING			R-C /02/2021
NAME OF PROVIDER OR SUPPLIER		STI	REET ADDRESS, CITY, STATE, ZIP COD	E	
		986	9 SW 152ND STREET		
CORAL REEF SUBACUTE CARE CE	NIERLLC	Mi.	AMI, FL 33157		
PREFIX (EACH DEFICIENCY I	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
of , diagnosis of  8 Review of Resident #1 sheets for the months of and was monitored for the leaded to the leaded to the leaded to the leaded to the use of the related to the use of the leaded to the leaded that Resident #1 was in behavior such as danger to self. Further monitoring sheets reve multiple episodes document of the leaded to the leaded the leaded to the leaded the l	Resident #1's clinical , diagnoses , diagnoses , diagnoses , and for the use of the use	F 656			

blank) for ....., ...., and during the day

		D HUMAN SERVICES MEDICAID SERVICES					M APPROVED O. 0938-0391
TATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		105910	B. WING	_		11.	/02/2021
	ROVIDER OR SUPPLIER SEF SUBACUTE CARE O	ENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 9869 SW 152ND STREET MIAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	monitored during that Laboratored during that Shavior Mc #1, showed that he his Afraid/Panic during the 7:00 AM) that occurre 15, 16, 17, 18, 19, 22 Review of nurses pro (From or record that address afraid/panic exhibited For the Month of) Residen sheet showed the res different episodes during the form of the for	PM) of	F	656	5		

The Behavior Monitoring Sheet dated

		ID HUMAN SERVICES MEDICAID SERVICES					M APPROVED D. 0938-0391
FATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		PLE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		105910	B. WING	_			/02/2021
NAME OF P	ROVIDER OR SUPPLIER			Γ	STREET ADDRESS, CITY, STATE, ZIP CODE		
CORAL R	EEF SUBACUTE CARE O	CENTER LLC			9869 SW 152ND STREET MIAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREF TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE COM			(X5) COMPLETION DATE
F 656	2021, showed that Rethree episodes. Two cocurred during the d PM) on of his. ). He also Afraid/Panic between lin noted "Routine OHS." only intervention was routine medication; tablet by at be progress notes for that addressed the after that addressed the progress notes for that addressed the brake with the progress of the behavior to the nurse reported and docume unusual for the patternight put the patternight pu	esident#1 had a total of pisodes of Afraid/Panic ay shift (7:00 AM to 7:00 on do not on the pisode of 7:00 PM to 7:00 AM shift on the pisode of 7:00 PM to 7:00 AM shift on the pisode of 1:00 PM to 7:00 AM shift on the pisode of 1:00 PM to 7:00 AM shift on the pisode of 1:00 PM to 7:00 AM shift on the pisode of 1:00 PM to 7:00 AM shift on the pisode of 1:00 PM to 7:00 PM t	F	65			

Resident # 1's physician orders included the

		ID HUMAN SERVICES					APPROVED
		MEDICAID SERVICES	1				0. 0938-0391
	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		E CONSTRUCTION		LETED
		105910	B. WING	_			-C 02/2021
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
				9	9869 SW 152ND STREET		
CORAL R	EEF SUBACUTE CARE C	ENTER LLC			MAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE			(X5) COMPLETION DATE
F 656	ordered one tablet by diagnosis of a for diagnosis of a for diagnosis of a for diagnosis of a great of the diagnosis of a for diagnosis of a for diagnose of the diagnose of a man diagnosis of do is monitor for side medication managem requires we monitor for monitor depending oresidents that are verifor verbalization, we symptoms. We docu behavior sheet and de specific behavior that skill nurses' notes. We for the use of for behaviors "Fear/P. According to the nurse sheavior monitoring sheavior monitoring sheavior sheavior monitors or for the diagnosis of the diagnosis of the diagnosis of the sheavior sheavior monitor of the diagnosis of	1 mg tablet, at at beditime for one tablet by and the Clinical Regional that Resident #1's clinical in of care that specifically or his dispersion of the comment of the course is also on the daily	F	656			

resident was showing frustration over his health. He did not like the . . . He did talk about it sometimes. He had . . . , on . . . . and

		ID HUMAN SERVICES					M APPROVED
		MEDICAID SERVICES					0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		LE CONSTRUCTION	1	PLETED
		105910	B. WING				-C 02/2021
NAME OF P	ROVIDER OR SUPPLIER			П	STREET ADDRESS, CITY, STATE, ZIP CODE		
				l	9869 SW 152ND STREET		
CORAL R	EEF SUBACUTE CARE O	CENTER LLC			MIAMI, FL 33157		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	2nd. The only interver documented on the b We do not have a b for the use of Clinical Regional Nurresidents record for a Resident #1's behavis actual written notes it resident's behaviors cand the Clinical Nurse documentation was n Interview on Psychiatrist explained indication that he was staff was "usually ver when there is any ind also past history, or a They usu evaluation I see me taking onsult for me If this gins or symptoms, ir or or or That has the saw Resident that his diagnoses inc Continue Psychiatrist on the Psychiatrist did nabove-mentioned befound in Resident #1' explained that he mel discussed the resider adjustments are neec	ntion was the medication as ehavior monitoring sheets ehavior monitoring sheets ehavior monitoring record The DON and se both agreed to review the ny notes that addressed ors, "We did not notice any lat addressed any of the or Both the DON shanger agreed such ecessary.  at 12:05 PM, the lith that the state of the state o	F	656	6		

of multiple documented episodes of afraid/panic noted on Resident #1's clinical record, The

		ID HUMAN SERVICES					APPROVED		
CENTERS FOR MEDICARE & MEDICAID SERVICES  TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MUL	(X2) MULTIPLE CONSTRUCTION			OMB NO. 0938-0391 (X3) DATE SURVEY		
ND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		A. BUILDING			LETED		
						R-C			
	105910		B. WING			11/02/2021			
NAME OF P	ROVIDER OR SUPPLIER		_		STREET ADDRESS, CITY, STATE, ZIP CODE				
					9869 SW 152ND STREET				
CORAL R	EEF SUBACUTE CARE O	ENTER LLC			MIAMI, FL 33157				
(X4) ID	ID SUMMARY STATEMENT OF DEFICIENCIES			_	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			COMPLETION DATE		
F 656	Continued From page	36	F	65	5				
	Psychiatrist reported	he was not aware of any of		-					
	Psychiatrist reported he was not aware of any of the above-mentioned behaviors. The nurses did								
		behaviors to him. The							
	Psychiatrist explained	I that the facility staff should							
	have communicated a	any , , , afraid/panic							
	episodes and other be								
		ell me I would definitely do							
		s usually call me. They did							
		e episodes. Had I known, I							
	would have definitely done something, would have gone to see him, maybe change the								
	medication"	, maybe change the							
	modication								
	On at 10:01 AM, Staff B Registered Nurse(RN) revealed; she normally								
		#1 three days a week from							
		The resident was alert and							
	oriented times three and communicated his								
		ally slept until about 9:00 AM							
	to 10:00 AM, participa								
	and liked to come out	day of the incident Resident							
	#1 was on isolation p								
		Staff B, RN stated: " I							
	worked from Thursda								
	Saturday	I monitored for							
	behaviors related to h	is use of , we							
	monitored for,	, fear, or, I don't							
	remember him having	any behavior. He							
		a little upset with the CNAs,							
		the door, close the window,							
		e! Generally, I document if							
		is constant. Normally, he							
	was easily re-directed								
		heet for the resident on the							
	days that I worked. I								

What I documented was that he had one behavior of . . . . , ." Staff B, RN explained that

		ID HUMAN SERVICES					M APPROVED		
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0. 0938-0391		
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		s	COMP	PLETED		
						l R	-C		
		105910	B. WING				02/2021		
NAME OF PE	ROVIDER OR SUPPLIER			Г	STREET ADDRESS, CITY, STATE, ZIP CODE				
HOURE OF TH	CONDEN ON OUT CALL			1	9869 SW 152ND STREET				
CORAL REEF SUBACUTE CARE CENTER LLC									
				L	MIAMI, FL 33157				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID.		PROVIDER'S PLAN OF CORRECTION	_	(X5) COMPLETION		
PREFIX TAG			PREF				DATE		
IAG	ALGOLATORT ON I	REGULATORY OR LSC IDENTIFYING INFORMATION)			DEFICIENCY)				
				_					
= 050									
F 656	Continued From page		F	F 656					
	Resident #1 kept aski	ing about the							
	( ) treatme	nt. The intervention, during							
	the , episode w	ras teaching about the							
	reason for the treatme	ent, what was the reason,							
	and why he remained	in isolation. Staff B stated							
	that her documentation	n on the behavior							
	monitoring sheets abo	out the afraid/panic episode							
	was related to the	treatment, that							
	Resident #1 received	the treatment and that it							
	was effective. Staff B	stated: "I did not document							
	in the nurses notes th	at the resident was having							
		ecause I did my action, I did							
		perate, he allowed me to							
		tment," Staff B reported that							
		havior monitoring sheet is							
	to follow for a prescrit								
	and document the ep								
		e resident is taking the							
		vention was to refer to							
		agreed there was no record					}		
	to explain anything at								
		ed: " It's established that a							
		ast three small episodes of							
		n if they have a big one. Big							
		ment on the nurses' notes.							
		ehavior monitoring sheet is							
	to see if the medication								
	throughout the month								
		ws is that the medication is							
	effective. I documente								
		and 4th. The one episode							
		ething like, "I don't want to							
	shower, I don't know	the behavior." Staff B then							
	agreed that the docur	nentation does not reflect							
	the exact nature, or d	etails of the behavior, she							
	did not know and cou	ld not recall the behavior.							
	Staff B stated: I also d	documented no behavior on							

10th, 11th, 16th, 17th, 24th, 25th, 26th. When I noticed the behavior, I did not report

DDINITED: 11/30/2021

		ID HUMAN SERVICES				FOR	M APPROVED
	S FOR MEDICARE & I	MEDICAID SERVICES (X1) PROVIDER/SUPPL(ER/CLIA	(MOV MATE	TIO	PLE CONSTRUCTION		O. 0938-0391 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:			PLE CONSTRUCTION 3		E SURVEY IPLETED
			11. 00120		<del>'</del>		R-C
		105910	B. WING	_			/02/2021
NAME OF P	ROVIDER OR SUPPLIER			Π	STREET ADDRESS, CITY, STATE, ZIP CODE		
CODALD	EEF SUBACUTE CARE O	PENTERILO			9869 SW 152ND STREET		
CORALIN	EEF SOBACOTE CARE C	SENTER EEG		L	MIAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFILITION DEFICIENCY)	BE	(XS) COMPLETION DATE
F 656	to anyone. I did not the communicate it to the monitor him for any of the time of	nink that I needed to psychiatrist. We did not I did not know he had rdiagnoses of Staff B explained reacted differently and that rery dangerous, levels of 's can change and crisis. "On that day he not seem depressed. He did mplaint of "Upon it #1's Diagnoses, Staff B issed that he had diagnosis	F	65			
	resident in his room a Record review of phy #1 showed a Telepho for a, managem of Resident #1's clinic documentation to ind correctived said, co Resident #1 returned with a diag His orders included for a diagnosis of,	nt consult. Further review call record showed no cate that Resident #1 nsult.  from the hospital on nosis of 10 mg, for five days.  Review of Resident #1's at no care plans on file that #1 diagnosis of ,					

Residents who have a diagnosis of

were audited to ensure they have an

, and

		ID HUMAN SERVICES					APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0. 0938-0391
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIP	LE CONSTRUCTION	(X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	NO	S	COMP	LETED
						R	-C
		105910	B. WING			11/	02/2021
NAME OF PE	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
					9869 SW 152ND STREET		
CORAL RI	EF SUBACUTE CARE O	ENTER LLC					
-				L	MIAMI, FL 33157		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREF	v	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	F	(X5) COMPLETION
TAG			TAG		CROSS-REFERENCED TO THE APPROPRIA		DATE
					DEFICIENCY)		
F 656	Continued From page	39	F	65	56		
	effective plan of care		1 '		~		
		and procedures to identify					
		ne in and behavior as					
		nd effectiveness of these					
	medications	to check teness of these					
		rector of Nursing (DON)					
		on a one-to-one basis					
		ursing Staff, and Social					
	Services regarding be						
		ng residents prescribed					
		, medications and					
		sk factors and changes in					
		s well as side effects.					
	Administrator/DON in	serviced all staff on a					
	one-to-one basis rega	arding and Neglect.					
	The Corporate nurse	consultant will in-service					
	administrative staff or	a one-to-one basis					
	regarding , neg	lect. informed care					
	and behavioral health	i.					
	Social services and n	ursing staff were educated					
	on a one-to-one basis	by Administrator/DON on					
	informed care	including a newly added					
	questionnaire regardi	ng					
	Newly hired staff will I						
		N/designee on monitoring					
	residents with diagno						
		nitor for behaviors related to					
		, and any noted side					
	effects of						
	medication as well as						
		cted an audit of all active					
	residents with a diagr						
		rescribed					
		ation to ensure they have					
	an effective plan of ca						
		and procedures to identify					
	risk factors and chang	ge in and behavior as					

well as side effects and effectiveness of these medication and to ensure behavior monitoring

		ID HUMAN SERVICES					FORM	M APPROVED
		MEDICAID SERVICES						0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		PLE CONSTRUCTION		(X3) DATE COMP	SURVEY
			A. BUILD	ING	3			
		105910	B. WING					t-C
		105910	D. WING	_			11/	02/2021
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
CORAL R	EEF SUBACUTE CARE O	CENTER LLC			9869 SW 152ND STREET			
				L	MIAMI, FL 33157			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE		(XIS) COMPLETION DATE
F 656	Continued From page	40		65	56			
, 000		nd reflect the behaviors of	'	u	7.0			
		side effects are monitored.						
		rill audit 100% of all active						
	residents with a diagr							
		ensure behavior sheets						
	reflect the resident's t							
	behaviors have interv	entions placed to intervene						
	with the behavior and							
		, medications are						
		e collected weekly for a						
		or one quarter then monthly						
	for the next two quart	ers. Social Il conduct informed						
	screening on all active							
	Sorcoming on an activ	o residents.						
	Regarding the facility	's failure to develop and						
	implement a compreh	nensive care plan:						
	The facility's removal	plan indicated: Residents						į.
	who are prescribed .							
		ns were audited to ensure a						[
		eveloped to effectively						
		ess and side effects of the						
	medication.							
	Residents who are pr	escribed, medication re a care plan is developed						
	to effectively manage							
		N educated facility staff on						
		cluding Licensed Nurses,						
	Certified Nursing Aide							
		n regarding residents who						
	are prescribed	and						
	medications to effecti							
		nedication and side effects.						
		IDS) Corporate consultant						
		one Inservice with MDS						
		an Inservice with nursing						
	staff regarding develo	ping and implementing a						

The Administrator/DON educated facility staff on

DEPARTMENT OF HEALTH AN	ID HUMAN SERVICES				FORM	APPROVED
CENTERS FOR MEDICARE &	MEDICAID SERVICES	_			OMB NO	0. 0938-0391
FATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		LETED
	105910	B. WING				-C 02/2021
NAME OF PROVIDER OR SUPPLIER			S'	TREET ADDRESS, CITY, STATE, ZIP CODE		
			98	869 SW 152ND STREET		
CORAL REEF SUBACUTE CARE O	ENTER LLC		м	IAMI, FL 33157		
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
Staff, Cartified Nursin following the care pla in order to effect symptoms. MDS conduct a noe-to-one and will conduct an let reparding developing care.  Newly hirred staff will in DON/designee during who are prescribed and , medication in monitor for the effect and side effects. An audit of all active it was conducted to end developed to effective and side effects of the Monitoring for Correct The DON or designee residents who are on and , medication in have been developed of the medications and Data will be collected twice a week for one next two quarters.  Related to: Accident I Devices failure to pro and accurately and et identify and treat chairs.	cluding Licensed Nursing g Aides on developing and in for Residents who have vely manage the Residents Corporate consultant will Inservice with MDS staff service with rursing staff and implementing a plan of the educated by the profession of the profession of the profession of the medication or residents who are on and, medication were a care plan has been ely monitor for effectiveness in medication with a care plan has been ely monitor for effectiveness in medication with a care plan has been ely monitor for effectiveness in medication with a care plan has been ely monitor for effectiveness in medication with a care plan has been ely monitor for effectiveness of monitor the effectiveness to monitor the effectiveness to monitor the effectiveness to monitor the effectiveness weekly for a month then quarter then monthly for the lazards, Supervision fectively monitored to toges in and s removal plan indicated:	F	656			

sheets are in place to identify behaviors, interventions placed to intervene with the

		ID HUMAN SERVICES MEDICAID SERVICES					M APPROVED 0. 0938-0391
STATEMENT OF DEF	ICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	SURVEY PLETED
10101010101		105910	A. BUILD B. WING			R	k-C (02/2021
NAME OF PROVIDE	ER OR SUPPLIER			Г	STREET ADDRESS, CITY, STATE, ZIP CODE	1	OZ. Z.OZ. (
CORAL REEF S	UBACUTE CARE O	ENTER LLC		1	9869 SW 152ND STREET MIAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
beh- and The a or Cert regg monor diag men Soc on a queue monidiag men monidiag men monidiag men diag men diag men monidiag men monidia	mental health ew. Administrator/DC e-to-one basis in ified Nursing Aide riding behavioral iltoring residents or nosis and to enst tal health evaluat ald services and n one-to-one basis informed car- stonnaire regardi ry hired staff will ration on behavis iltoring residents or to ensure to ensure to ensure in place and refle- dent and that refe tent ensure in place and refle dent and that refe tent and that refe tent end that refe tent ensure in place and refle dent and that refe tent ensure in place and refle sent ensure in place so the tent ensure in place and refle sent ensure in place end sent ensure in place	Is made for aluations. No educated facility staff on cluding Licensed Nurses, is and Social Services health with emphasis on with and ure referrals are made for ions. urusing staff was educated by Administrator/IDON on is including a newly addeding or educated the control of	F	656	6		

Observations on revealed sampled residents with diagnosis of . . . . or . . .

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				FOR	M APPROVED
CENTER	S FOR MEDICARE & I	MEDICAID SERVICES				OMB N	O. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	COM	E SURVEY IPLETED R-C
		105910	B. WING	_		- 1	1/02/2021
NAME OF P	ROVIDER OR SUPPLIER			Γ	STREET ADDRESS, CITY, STATE, ZIP CODE		
		ENTER LLO			9869 SW 152ND STREET		
CURAL K	EEF SUBACUTE CARE C	ENTERELC			MIAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFILE OF THE APPROPROPROPERTY)	BE	(X5) COMPLETION DATE
F 656	provided care and sea bout the safety and were noted during observed to the safety and were noted during observed to the safety and the safet	edication were being vices and no concerns well-being of the residents servations.  20 AM, the Nursing Home stated that she provided one training session to all ere fully trained and raining was provided to all lude the monitoring and itude the monitoring itude to the correct information on the heets.  Ion/In-Services logs until Monitoring residents and behavior Monitoring residents and monitoring residents and services. Able to identify risk in and behavior Able to identify risk in services and service	F	65	56		

the one to one (1:1) Education/In service dated ..... provided by Corporate to the

		ID HUMAN SERVICES MEDICAID SERVICES					APPROVED 0. 0938-0391
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION	(X3) DATE	
		105910	B. WING				-C 02/2021
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
CORAL R	EEF SUBACUTE CARE O	CENTER LLC		1	9869 SW 152ND STREET MIAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	Administrator, Assist Review of the in-servine revealed 75 nursing staff. On training was provided of the Social Services Depa Planning staff. On provided to 8 staff me staff) and (1 strinservice was provided for residents who are and of the medication.  Record review of the audit to for residents who are and of the medication.  Record review of the Procedures for Care I Person-Centered was The Resident Policy 1-800-96.  The facili Intervention and Mon was revie facility's policy for was revied.  On at 06. Coordinator revealed training from DON at Nurse. The training whe was encoding presumenting that if the personsuring that it is the personsuring that if the personsuring that it is the personsured t	ant, Director of Nursing.  ce logs dated to  ce logs dated to  in-service  by the three staff members  Department, (3 staff from  riment), MDS and Care  in-service was  mbers. On (1  str), On  at to new hires.  gs revealed weekly audits  on  medication and side effects  facility's Policy and  Plans, Comprehensive  ir evised on  vegs revised on  vegs deviced as sessment,  itoring last revised  wed with no concerns. The  informed Care revised  wed.  43 PM, Staff D, MDS  she received in service  d Corporate Regional  as basically to ensure that  perfy the Care Plans,  tient has a diagnosis of  or , to make sure	F	656	6		

side effects and monitoring the effectiveness of the medication. Staff D stated that if she read

PRINTED: 11/30/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND REAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING R-C 105910 R MING 11/02/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9869 SW 152ND STREET CORAL REEF SUBACUTE CARE CENTER LLC MIAMI, FL 33157 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES. (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 656 Continued From page 45 F 656 anything in the chart that triggers or when talking to resident or family to communicate with direct care provider (nurse for the patient). Also, during the assessment look to see if resident has any ..... and also when patient receiving the \_\_\_\_ medication to ensure the behaviors are noticed both on the care plan and to ensure that every patient has behavior sheet and make sure the behaviors sheets match the medication administration records for the medication and the Care Plan. Monitoring the behaviors is done by the nurses providing direct care and any staff in the building that observed any signs for symptoms pertaining to ..., and for them to report it immediately to administration or supervisor. Review of the audit logs revealed weekly audits for residents who are on , and , medication and side effects of the medication. Record review of the facility's Policy and Procedures for Care Plans, Comprehensive Person-Centered was revised on The Resident Neglect and Policy 1-800-96- ... was revised on . The facilty's Behavioral Assessment, Intervention and Monitoring last revised was reviewed with no concerns. The facility's policy for . . . Informed Care revised was reviewed. (F 684) Quality of Care (F 684) SS=D 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

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FORM APPROVED	
OMB NO. 0938-0391	
(X3) DATE SURVEY	

CENTERS FOR MEDICARE & MEDICAID SERVICES OM					
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	105910	B. WING		11/02/2021	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
			9869 SW 152ND STREET		

		105910	B. WING			11/02/2021	
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
		ENTER LLO	1	5	869 SW 152ND STREET		
CURAL R	EEF SUBACUTE CARE C	ENTERELL		1	MAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  * MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ę	(X5) COMPLETION DATE
{F 684}	facility residents. Basi assessment of a resis that residents receive accordance with profe practice, the compreh care plan, and the res resident plan, and the res resident plan, and the resident plan, and the resident plan, and the resident plan, and the resident planning, monitoring response to manager response to manager response to manager response to manager and unsupervised by one (I sampled residents resurvey. The facility fail behaviors related to Forgon and unsupervised in his reminded to the resident plan planning in the penis, con miligram in the penis, con interpretation in the penis, con interpretation in the penis, con in the penis, con interpretation in the penis con interpretation in the penis con interpretation in the penis con	ed on the comprehensive led on the comprehensive lent, the facility must ensure treatment and care in sessional standards of ensive person-centered idents' choices.  Is not met as evidenced is not met as evidenced is not met as evidenced icos such as the care sasessement and consistent liaignoses of, Resident #1) out of 10 riewed during a complaint led to effectively monitor lesident #1's diagnoses of , and , While om, Resident #1's uffocated ash bag over his  sician's orders for Resident te order dated consult. Further review of record showed no esident #1' received said hurse's notes dated AM to 7:00 PM shift was administered two (mg) tablets because of	任仓	84}			

		ID HUMAN SERVICES MEDICAID SERVICES					APPROVED 0. 0938-0391
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE COMP	SURVEY
		105910	B. WING				-C 02/2021
NAME OF P	ROVIDER OR SUPPLIER	•	_	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
CORAL R	EEF SUBACUTE CARE (	CENTER LLC			9869 SW 152ND STREET MIAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
(F 684)	Record review of the showed that Residen Hospital on penal and "Diagnoses during thi ( ). Site n device, ancounter"  Record review of phy revealed, the Hospital on He was completed the Hospital on He was completed also diagnosed with reverse of clinical recreturned to the nursing Review of physician characteristics of the nursing the state of the nursing the n	Clinical Transition of Care ##1 arrived to the to the ##1 arrived to the to the at 20:12, with diagnoses of problem. s visit" noted: of specified. Unspecified e	₹F €	584}			
	Nurse ( LPN) dated .	C a Licensed Practical at 12:30 noted " police called, resident					

observed banging on his bed and yelling, stating

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		105910	B. WING				02/2021
NAME OF P	ROVIDER OR SUPPLIER		•	Γ	STREET ADDRESS, CITY, STATE, ZIP CODE		
CORAL R	EEF SUBACUTE CARE O	ENTER LLC			9869 SW 152ND STREET MIAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
(F 684)	that he had severe to the hospital. ABD ( soft, non-tender, voice region. Ca Doctor] to send to he place to 911 emerger assessed patient, and closest hospital at 11: Resident #1 returned with diagnorders included diagnosis of . Record review of produced to the continuation of the conti	and requested to be sent abdornen) assessed noted et at the touch of lower il placed to MD [Medical spital for evaluation. Call cyc, Paramedics arrived, I transferred him to the 30 PM.  from the hospital on poiss of His 10 mg for five days for for five d	(F 6	6684	4)		

at 6:00 PM with Resident #4 revealed he was close friends with

TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE			ID HUMAN SERVICES					APPROVED
AND PLAN OF CORRECTION    DENTIFICATION NUMBER:   A. BUILDING   COMPLETED	CENTERS FOR	R MEDICARE &	MEDICAID SERVICES		_		OMB NO	0. 0938-0391
105910   B. WING								
CORAL REEF SUBACUTE CARE CENTER LLC    9869 SW 152ND STREET   MIAMI, FL 33157     00,100   SUMMARY STATEMENT OF DEFICIENCIES   D. PROVIDER'S PLAN OF CORRECTION   DOS, PRICEY (EACH DEFICIENCY MUST BE PRECEDED BY PULL   PREFIX   GROUNDER'S PLAN OF CORRECTION SHOULD BE COMPLETED AND CONTRACT OF CONTRACT OF CONTRACT OF CONTRACT PROPORATION   TAG   CROSS-REFERENCED OT DISTRICT PROPORATION   TAG   TAG			105910	B. WING	_			
CORAL REEF SUBACUTE CARE CENTER LLC  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES  (X4) ID PROVIDERS PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY PLUL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPAET TAG REGULATION FOR ISC DETENTIVEN MORPOMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE  OFFICE OF THE PROPERTY OF THE	NAME OF PROVIDE	ER OR SUPPLIER			٤	STREET ADDRESS, CITY, STATE, ZIP CODE		
DAI   D   SUMMARY STATEMENT OF DEFICIENCIES   D   PROVIDER'S PLAN OF CORRECTION   DS]   PREFIX   (EACH DEFICIENCY MUST BE PRECEDED BY PULL   PREFIX   (EACH CORRECTIVE ACTION SHOULD BE COMPLET AGO   REGULATORY OF ISS   DEPINTING IN PROFINATION   TAG   CROSS-REFERENCED TO THE APPROPRIATE   DEPINTING IN PROFINATION   TAG   PROVIDER PREFIXED CONTINUED   TAG   PROVIDER PROFINATION   TAG   PROVIDER PREFIXED CONTINUED   TAG   PROVIDER PROFINATION   TAG   PROVIDER PROVIDER PROVIDER PROFINATION   TAG   PROVIDER PROVIDE					g	869 SW 152ND STREET		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	CORAL REEF SI				L	,		,
DE IOLITO)	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD B		(X5) COMPLETION DATE
Resident #1. Resident #4 had a score of 14 out of 15 on the  ( ), which indicated the resident was able to verbalize his needs and was not .  Further review of the Minimum Data Set (MDS) revealed that Resident #4 had a clear speech pattern and was able to understand others as well as make self-understoot. During the interview, Resident #4 reported he was friends with Resident #4 and hung out with him almost every day. Resident #4 reported he was friends with Resident #1 and hung out with him almost every day. Resident #4 reported he was suffering, As if peeing razor bladdes" Resident #4 reported that the last times he saw his friend on and "Resident #1 peeing razor bladdes" Resident #4 reported that Resident #1 talked about how he just could not take it anymore and he wanted "to go home, meaning go to heaven."  Record review of Resident #1's MAR and treatment records for showed no record to indicate the facility addressed the resident's , Further review of the MAR for	Resis 15 or ( ) verb.  Set ( ) speed other the in the interest of the the the interest of the	on the probability of the probab	It #4 had a score of 14 out of led the resident was able to not was not view of the Minimum Data half Resident #4 had a clear vas able to understand se self-understood. During nt #4 reported he was #1 and hung out with him sident #4 explained that the friend on and nt #1 ] was in a lot f, _, he eeing razor blades' Resident ident #1 talked about how it anymore and he wanted g go to heaven."  sident #1's MAR and showed no facility addressed the her review of the MAR for and the wasted of the resident with the way of the wasted of	⟨F €	i84}			

		ID HUMAN SERVICES MEDICAID SERVICES					APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		LE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED -C
		105910	B. WING	_		11/	02/2021
	ROVIDER OR SUPPLIER EEF SUBACUTE CARE O	CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 9869 SW 152ND STREET MIAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
(F 684)	and scale in the MAR every shift. "Staf Resident #1 had conc "He had could be painful, discomfort" During of Resident #1's reco was discharged from orders for diagnosis c mg, one tablet to be a 6 hours for 5 days to 15 days of 1	Our job is to assess for 16 acknowledged that iftions that could cause , as one of his diagnoses, sensation, the interview, clinical review rick showed that the resident the community hospital with if, and for 10 diministered by every histard date of 10 diministered the medication Staff G stated, "It earns I have to give it to him, with the "Staff G stated," It earns I have to give it to him, with the "Staff G stated," It earns I have to give it to him, with the "Staff G stated," It earns I have to give it to him, with the "Staff G stated," It earns I have to give it to him, with the "Staff G stated," It earns I have to give it to him, with the "Staff G stated," It have revealed she well. Staff three days a 7:00 PM. Staff B reported alert and oriented times incited his needs well. Staff that Resident #1 had, rhe did at some point take and for about vas not able to explain why ro (0). For the entire and insisted that we, the last times she sday, 10 staff. Those	(F. 6	5844	).		

documented that Resident #1 called the police because he was in so much , on ......

		ID HUMAN SERVICES MEDICAID SERVICES					M APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE COMP	
		105910	B. WING				02/2021
NAME OF PE	ROVIDER OR SUPPLIER		•	1	STREET ADDRESS, CITY, STATE, ZIP CODE		
CORAL RI	EEF SUBACUTE CARE O	ENTER LLC		1	9869 SW 152ND STREET MIAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
(F 684)	and on the night that ( ).  On at 12 interview Staff C, LPh message was left. Or Staff C was called ag the phone and request in 15 minutes. C was called, Staff C had any complaints. When a that the resident had disconnected. On up telephone interview that the resident had disconnected. On up telephone interview as the staff C report of the care, Staff C report as the staff C report of the care, Staff C report of the care, Staff C report of the complaining of so mu to clarify the documer indicated that the resident declarify the documer indicated that the resident Staff C report of the complaining of so mu colarify the documer indicated that the resident Staff C report of the property of the complaining of so mu colarify the documer indicated that the resident of the property of the control of the property of the complaining of so mu colarify the necessary of the property of the pro	he committed	{F €				
	§483.25(d) Accidents The facility must ensu						

§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and

		ID HUMAN SERVICES MEDICAID SERVICES					APPROVED 0.0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	
NO POUVOE	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING		COMPLETED	
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		105910	B. WING	_		11/	02/2021
NAME OF PE	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
				ı	9869 SW 152ND STREET		
CORAL RI	EEF SUBACUTE CARE O	ENTER LLC			MIAMI, FL 33157		
	CUMMANDVCT	ATEMENT OF DEFICIENCIES	1D	_	PROVIDER'S PLAN OF CORRECTION		
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	PREF	EΧ	(EACH CORRECTIVE ACTION SHOULD E	Æ	(X5) COMPLETION
TAG		SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRI		DATE
					DEFICIENCY)		
(E 000)	0 5 15						
{F 689}	Continued From page	152	{F €	589	3)		
	§483.25(d)(2)Each re	sident receives adequate					
		tance devices to prevent					
	accidents.						
		is not met as evidenced					
	by:	to a district to the second					
		viewed and interviews, the					
	facility failed to ensure						
		vision was provided for one					
	resident (Resident #1						
		esidents that received and 47 residents that					
		medications. The facility					
		onitor behaviors related to					
	Resident #1's diagnos						
		of panic and afraid which					
		elf-inflicted harm. Resident					
		d in his room, placed a					
		his and suffocated					
	himself resulting in	by .					
		it was determined the					
		posed immediate jeopardy					
		ty of all residents admitted					
	to the facility.	,					
	On the fa	cility's Immediate Jeopardy					
		rified by the survey team					
	through record review	s and interviews. It was					
		ity completed in-services for					
	all staff on	related to the Immediate					
	Jeopardy deficiencies	i.					
	The scope and seven	ty was lowered as a result					
	of the facility's correct	tive actions implemented.					
	The immediate jeopa	rdy was determined to be					
	removed on						
	The scope and sever	ty for F689 were lowered to					
	a (D) for No actual ha	rm with a potential for more					
	than minimal harm the	at is not immediate jeopardy					

		ID HUMAN SERVICES					APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	1	PLETED
		105910	B. WING				-C 02/2021
NAME OF PE	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
				١,	9869 SW 152ND STREET		
CORAL RI	EEF SUBACUTE CARE O	ENTER LLC			MIAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 689}	Continued From page The Findings Included	d:	{F €	89)	)		
	was admitted to the fa Resident #1 was an a resident with physical wheelchair and is able	at 9:00 PM, Resident #1 acility on					
	bathroom on his own would ask for assistar found by Certified Nu	and was independent but noe if he needed it was rsing Assistant (CNA) Staff A ir his The facility's					
		ed the code and initiated					
	Residents." Revised in	fety and Supervision of n , revealed the					
	environment as free f possible. Residents'	r facility strives to make the rom accident hazards as safety and supervision and					
	commitment to safety organization.						
	"Employees shall be to and demonstrate com	pach to safety included: trained on potential hazards apetency on how to identify					
	avoidable accidents. resident-centered app	proach to safety included:					
	to safety addresses s for individual resident	resident centered approach afety and accident hazards s. 2.The interdisciplinary					
		ze information obtained d observations to identify s hazards or risks for					

individual residents. 3. The care team shall target

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	105910	B. WING	11/02/2021
			R-C
PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	COMPLETED
ATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
CENTERS FOR MEDICARE &	MEDICAID SERVICES	1	OMB NO. 0938-0391
DEPARTMENT OF REALTH AN	ID HUMAN SERVICES		FORM APPROVED

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9869 SW 152ND STREET CORAL REEF SUBACUTE CARE CENTER LLC MIAMI, FL 33157 SUMMARY STATEMENT OF DEFICIENCIES. PROVIDER'S PLAN OF CORRECTION COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (F 689) Continued From page 54 {F 689} interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices. Systems approach to safety noted: 2. Resident supervision is a core of the systems approach to safety. Review of the care plans for Resident #1 revealed, care plan dated : "Resident ...,/agitation. # 1 exhibited behaviors of Goals: Resident #1 will be able to display appropriate response to situations by next review date." Approaches included, determine cause of ..., observe for changes in mental status, ., and behavior, notify MD (Medical Doctor) of changes as needed. Further review of the care plans showed that Resident #1 had diagnoses of ..... and was at risk for alterations in pattern. Approaches included, observe for ..., encourage verbalization of changes in feelings, administer as ordered. Record review of Resident #1's behavior monitoring sheets for ..., ..., ... , indicated that Resident # 1 was monitored for the behaviors afraid/panic. Related to the use of 1 milligram (mg) tablet. There was no record to indicate that Resident #1 was monitored for any other behavior such as .... changes or danger to self. There was no behavior record to indicate that he was monitored for his diagnosis of and for the use of Further review of the behavior monitoring sheets showed that Resident #1 had multiple episodes documented as "Afraid/Panic". The behavior monitoring sheet initiated on indicated Resident #1 had a total of 9 episodes of

Afraid/Panic. Five out of nine different enisodes. occurred during the hours of 7:00 AM to 7:00 PM

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		LE CONSTRUCTION	(X3) DATE	SURVEY LETED
NO POW OF	CORRECTION	IDENTIFICATION NOMBER.	A. BUILD	ING		COMPLETED	
						R	-C
		105910	B. WING	_		11/	02/2021
NAME OF PI	ROVIDER OR SUPPLIER			Г	STREET ADDRESS, CITY, STATE, ZIP CODE		
				1	9869 SW 152ND STREET		
CORAL R	EEF SUBACUTE CARE O	CENTER LLC			MIAMI, FL 33157		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	JD.	_	PROVIDER'S PLAN OF CORRECTION		(305)
PREFIX		Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD E		COMPLETION DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	DATE
					DEFICIENCY)		
(E 000)	0 5 15						
{F 689}	Continued From page		{F €	889	<del>!</del> }		
		), and 25. Four different					
	episodes of Afraid/Pa	nic occurred between the					
	hours of 7:00 PM to 7	7:00 AM, on,, 27					
	and 28. The documer	nted interventions for each					
	episode noted "Routing	ne."					
	Review of the nurses'	progress notes for .					
	, showed no reci	ord that addressed any of					
		exhibited by Resident #1.					
		,,					
	Review of the behavior	or sheets for					
		ted date of, but the					
		sheet showed no record (left					
		, and during the day					
	shift (7:00 AM to 7:00						
	indicating that Reside						
		of monitored during that time.					
		behavior monitoring records					
		ved that Resident #1 had 15					
		Afraid/Panic during the 7:00					
		The Afraid/Panic behaviors					
		ed on , 9, 10, 11, 13,					
		2, 23, 24, 25 and 29. Review					
		ss notes for,					
	showed no recorded						
		afraid/panic episodes					
	exhibited by Resident	i #1.					
	Pavious of Pacidant #	1's behavior sheets for					
	(initi						
		had a total of 17 different					
		anic during the month of					
		17 different episodes of					
		between 7:00 AM to 7:00					
		3, 4,and 5. The intervention					
		Routine QHS [nightly at					
	bedtime]". Further						
	behavior monitoring r	ecord showed that Resident					

#1 had 13 out of 17 different episodes of Afraid/Panic during the evening shift (7:00 PM to

		ID HUMAN SERVICES MEDICAID SERVICES					M APPROVED O. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		ONSTRUCTION	(X3) DATI	E SURVEY IPLETED
		105910	B. WING				R-C 1/02/2021
NAME OF P	ROVIDER OR SUPPLIER	•		STF	REET ADDRESS, CITY, STATE, ZIP CODE		
CORAL R	EEF SUBACUTE CARE (	CENTER LLC			9 SW 152ND STREET AMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
(F 689)	7:00 AM) on 20, 21, 24, 26, 27 am intervention noted, "Review of Nurses No showed no recorded addressed the episoc by Resident #1.  Review of the behaving the properties of t	. 7, 12, 13, 14, 17, 19, 12, 12, 17, 19, 11, 12, 17, 19, 11, 12, 17, 19, 11, 19, 11, 19, 11, 19, 19, 19, 19	₹ <b>F</b> €	(89)			

Technicians] pronounced his . . . . No obvious

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0. 0938-0391	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIP.	PLE CONSTRUCTION	(X3) DATE		
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	iNG	š	COMP	PLETED	
						l R	-C	
		105910	B. WING	_		11/	02/2021	
NAME OF PE	ROVIDER OR SUPPLIER			Г	STREET ADDRESS, CITY, STATE, ZIP CODE			
				ı	9869 SW 152ND STREET			
CORAL RI	EF SUBACUTE CARE O	CENTER LLC			MIAMI, FL 33157	3157		
-				L			,	
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREF	īV	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E		(X5) COMPLETION	
TAG		SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRI		DATE	
					DEFICIENCY)			
{F 689}	Continued From page	57	{F €	389	9)			
	injuries were noted at	the time of CNA						
		ent verbalized that he was						
		om. The CNA stated he had						
		open the door. CNA stated						
		as pushed against the door						
		the wheelchair. Trash bag						
		. CNA stated he removed						
		f patient was not breathing.						
		hing per CNA statement.						
		to me and to the police how						
	he found the patient.	Family was notified by						
	police. Police officer s	spoke to [ Emergency						
	Contact]. The medica	l examiner arrived and						
		body out of the facility."						
	Review of the investig	gative report and interview						
		onal Nurse on						
	approximately 2:30 P	M revealed, the Clinical					}	
	regional nurse had re	viewed the facility's video					}	
	recording as she inve	stigated the event. The					-	
	Clinical Regional Nur	se documented her						
	observation of the vid	leo and reported that she						
	reviewed the video re	cording on "Tuesday or						
	Thursday last week."	The report noted that on						
	Saturday a	it 2:54 PM Resident #1's						
	CNA, (Staff A) went in	nto the residents' room						
	[room #] at 4:18 PM.	Nurse (Staff B) was passing						
	meds. The Clinical Re	egional Nurse stated: "You						
	can see her going in a	and out of rooms." At 4:30						
		dent #4) leaves Resident #						
	1's room. The video s	howed that at 4:52 PM meal						
	was delivered to Resi	ident #1's room. His door						
	remained open the wi	hole time. At 5:21 PM the						
	Nurse [Staff B] went i	nto Resident #1's room. At						
	5:43 PM the CNA (St	taff A) picked up the tray,						
	(Noted that he ate 10	0%). At 6:25 PM it appears						
		ingide the room. No one					ł.	

checked on the resident or attempted to enter the room from approximately 6:25 PM to 8:15 PM

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0. 0938-0391
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION		LETED
		105910	B. WING				-C 02/2021
NAME OF PR	ROVIDER OR SUPPLIER			Г	STREET ADDRESS, CITY, STATE, ZIP CODE		
				ı	9869 SW 152ND STREET		
CORAL RI	EF SUBACUTE CARE O	CENTER LLC		L	MIAMI, FL 33157		
(X4) ID		ATEMENT OF DEFICIENCIES	1D		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL .SC (DENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE
TAG	REGULATURY OR I	SCIDENTIFING INFORMATION	IAG		DEFICIENCY)	are;	
{F 689}	Continued From page	58	{F €	889	3)		
	(Staff C) LPN was sol	heduled to start her shift at					
		n that she checked on					
		time her shift started until					
		around 8:15 PM. At 8:15					
		get into the room and noted					
		sed. The CNA tried to open					
		locked. Staff A was in the					
		d, leaves the area gets the					
		cart The Regional nurse					
		IA had to push the door					
		tered, the room he noted					
	Resident #1 seated in						
		pag over his The CNA					
		the bag off Resident #1's					
		elp. A code was called as					
		onded to this resident's					
		sferred him to the bed, a					
	backboard was place						
	enforcement and EM						
		inced this Resident. The					
		ransferred to the Medical					
	Examiner's office.						
	During an interview o	n at 10:56 AM					
		ted he did not review the					
		navior monitoring sheets in					
		record. The Psychiatrist					
		with the facility's staff and					
	discussed residents'						
		led. When asked about chiatrist reported he was not					
		# 1 had any behaviors. Upon					
		tiple documented episodes					
		on Resident #1's clinical					
		st reported he was not					
		urses had not communicated					
		The Psychiatrist explained					
	that the facility staff sl	hould have communicated					

..., afraid/panic episodes and any other

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				FORM	APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0. 0938-0391
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPE	LE CONSTRUCTION	(X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	NG	·	COMP	LETED
						R	-C
		105910	B. WING	_		11/	02/2021
NAME OF PE	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
		TENTED I I O			9869 SW 152ND STREET		
CURAL RE	EF SUBACUTE CARE O	SENTER LLC			MIAMI, FL 33157		
(X4) ID		ATEMENT OF DEFICIENCIES	1D	_	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	REGULATURY OR I	SC IDENTIFTING INFORMATION)	TAG		DEFICIENCY)	115	57.11.0
-					<del></del>		
(F 689)	Continued From page	- 50			22		
11 00001	, ,		{F €	009	7		
		Resident#1 to him. "If they					
		ely do something. The e. They did not tell me about					
		d I known, I would have					
		hing, I would have gone to					
	see him, maybe chan						
		<b>9</b>					
	The facility's removal	plan included:					
	Residents who have a						
		ited to ensure they have an					
	effective plan of care						
		and procedures to identify					
	risk factors and chang						
	well as side effects ar medications	nd effectiveness of these					
		rector of Nursing (DON)					
		on a one-to-one basis					
		ursing Staff, and Social					
	Services regarding be						
		ing residents prescribed					
	. and	, medications and					
	identifying possible ris	sk factors and changes in					
		s well as side effects.					
		serviced all staff on a					
	one-to-one basis rega						
		consultant will in-service					
	administrative staff or						
		lect informed care					
	and behavioral health						
		ursing staff were educated s by Administrator/DON on					
		e including a newly added					
	questionnaire regardi						
	Newly hired staff will I						
		N/designee on monitoring					
	residents with diagno						
		onitor for behaviors related to					

and . . . , and any noted side

DDINITED: 11/30/2021

DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES					APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES					0. 0938-0391
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		105910	B. WING	_			-C 02/2021
NAME OF PR	ROVIDER OR SUPPLIER			Г	STREET ADDRESS, CITY, STATE, ZIP CODE		
					9869 SW 152ND STREET		
CORAL RI	EEF SUBACUTE CARE O	CENTER LLC			MIAMI, FL 33157		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	1D	_	PROVIDER'S PLAN OF CORRECTION		(3(5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
(F 689)	Continued From page	.60	{F 6	:00			
(1 000)			11-6	903	7		
	effects of						
	medication as well as						
		cted an audit of all active					
	residents with a diagr						
		rescribed					
		cation to ensure they have					
		are in conjunction with					
		and procedures to identify					
		ge in and behavior as					
		nd effectiveness of these					
		sure behavior monitoring					
		nd reflect the behaviors of					
		side effects are monitored. rill audit 100% of all active					
	residents with a diagr						
		ensure behavior sheets					
	reflect the resident's t						
		entions placed to intervene					
	with the behavior and						
	and	medications are					
		e collected weekly for a					
		or one quarter then monthly					
	for the next two quart						
	Services/designee wi						
	screening on all active						
	Regarding the facility	's failure to develop and					
	implement a compreh						J
		plan indicated: Residents					
	who are prescribed	, and					
	medication	ns were audited to ensure a					
		eveloped to effectively					
	monitor for effectiven	ess and side effects of the					
	medication.						
	Residents who are pr	escribed , medication					
		re a care plan is developed					
	to effectively manage	the ,					
	The Administrator/DC	N educated facility staff on					

a one-to-one basis including Licensed Nurses,

DDINITED: 11/30/2021

		ID HUMAN SERVICES				FORM	APPROVED	
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0. 0938-0391	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		105910	B. WING				-C 02/2021	
NAME OF P	ROVIDER OR SUPPLIER			8	TREET ADDRESS, CITY, STATE, ZIP CODE			
				9	869 SW 152ND STREET			
CORAL R	EEF SUBACUTE CARE O	ENTER LLC		٨	MAMI, FL 33157			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI- DEFICIENCY)		(X5) COMPLETION DATE	
(F 689)	are prescribed medications to effectiveness of the m Minimum Data Set (M will conduct a one-to-staff and will conduct staff regarding developlan of care. The Administrator/DC a one-to-one basis in following the care pla in order to effect symptoms. MDS conduct a one-to-one development of the modern of the care pla in order to effect symptoms. MDS conduct a one-to-one and will conduct an Ir regarding developing care. Newly hired staff will DON/designee during who are prescribed and , medication monitor for the effective and side effects. An audit of all active to was conducted to effective during who are prescribed on the conductive of the developed to effective and side effects of the Monitoring for Correct The DON or designee residents who are on and , medication have been developed to	es on developing and negariting residents who and vely monitor for the edication and side effects. BIOS) Corporate consultant one Inservice with MDS an Inservice with MDS an Inservice with MDS an Inservice with with most an inservice with morsing ping and implementing a live ducated facility staff on cluding Licensed Nursing g Aides on developing and in for Residents who have vely manage the Residents S Corporate consultant will Inservice with MDS staff service with mursing staff and implementing a plan of one educated by the corientation on residents who are on exidents who are on and, medication recidents who are on and, medication for effectiveness medication for effectiveness medication redication for effectiveness medication redication redication for effectiveness medication redications.	₹F €	589)				

Data will be collected weekly for a month then twice a week for one quarter then monthly for the

		D HUMAN SERVICES					M APPROVED
		MEDICAID SERVICES					0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL' A. BUILDI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		105910	B. WING			1	I-C 102/2021
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
				١,	9869 SW 152ND STREET		
CORAL R	CORAL REEF SUBACUTE CARE CENTER LLC				MIAMI, FL 33157		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	N SHOULD BE E APPROPRIATE	
{F 689}	Continued From page next two quarters.		{F €	89	}		
	Related to: Accident I Devices failure to pro and accurately and et identify and reat chai behaviors, the facility Residents who have a were audishes a relative to the season of the se	wide adequate supervision feetively monitored to and					
	resident and that refe conducted as warrant or designee will audit diagnosis of	rrais for mental health are ted from the audit. The DON 100% of residents with a and, to ensure theets accurately reflect					

resident's behaviors. Data will be collected weekly

		D HUMAN SERVICES					RM APPROVED	
CENTER	S FOR MEDICARE &	MEDICAID SERVICES					NO. 0938-0391	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD			(X3) DATE SURVEY COMPLETED R-C		
		105910	B. WING	_		,	11/02/2021	
NAME OF P	ROVIDER OR SUPPLIER			Г	STREET ADDRESS, CITY, STATE, ZIP CODE			
CORAL R	EEF SUBACUTE CARE O	CENTER LLC		1	9869 SW 152ND STREET MIAMI, FL 33157			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFICIENCY)	BE	(X5) COMPLETION DATE	
(F 689)	then monthly for the r Services/designee wi informed screening or The facility's removal onsite visit on interviews conducted Observations on residents with diagno and receiving me provided care and sei about the safety and were noted during ob On at 10- Administrator (NHA) is education and one to staff to ensure staff w knowledgeable. The I-60 employees to inc documenting of any s assessed and identific and to provide the behavior monitoring is Review of the Educa provided dated topics included: Documentation. Prog sheets. Monitor for for and prescribed medications effective informed Care.	a week for one quarter with two quarters. Social I conduct the an all active residents.  plan was verified during an and telephone on revealed sampled sis of or addication were being vices and no concerns well-being of the residents servations.  Do AM, the Nursing Home stated that she provided one training session to all rear fully trained and raining was provided to all lude the monitoring and futuation with residents ed for e correct information on the heets.	{F •	589				

factors and changes in and behavior. Able to identify side effects of ..., and

		ID HUMAN SERVICES MEDICAID SERVICES					M APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDI		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		105910	B. WING			11/	02/2021
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
CORAL REEF SUBACUTE CARE CENTER LLC					9869 SW 152ND STREET MIAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
(F 689)	health evaluation. Ca monitor for effectivene effects. Docume effects. Docume and following care pla in order to effect symptoms. Able to ide effectively manage th the one to one (1:1) E provided Administrator, Assist Review of the In-servi revealed 75 nursing staff. On training was provider of the Social Services Depa Planning staff. On provided to 8 staff me staff) and(1 st in-service was provide Review of the audit to for residents who are a, and, of the medication.  Record review of the Procedures for Care I Person-Centreed was The Resident Policy 1-800-96. The facil Intervention and Mon was review	ns. Referral for mental re Plan: , to effectively sess of meds and side ministation accuracy developing ans for residents who have tively manage their, and entify, symptoms and e resident's. Review of cucation/in service dated by Corporate to the ant, Director of Nursing. ice logs dated to education was provided to in-service by the three staff members in-service in-service was subsets. On  (1  aff), On  et on one whires, ges revealed weekly audits on medication and side effects facility's Policy and Plans, Comprehensive revised on was revised on ly 58 Behavioral Assessment,	₹F €	889	) 		

was reviewed.

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				FORM	APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES					0.0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		105910	B. WING				-C 02/2021
NAME OF PROVIDER OR SUPPLIER				Г	STREET ADDRESS, CITY, STATE, ZIP CODE		
CODAL D	EEF SUBACUTE CARE O	PENTERILO			9869 SW 152ND STREET		
CORAL K	EEF SOBACOTE CARE C	ZENTER EEG			MIAMI, FL 33157		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTING PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPROLEMENT OF THE APPROLEMEN			(X5) COMPLETION DATE
{F 689}	and 34 Certified Nurs and the te revealed to the facility's staff a to explain understand	with 21 licensed nurses ing Assistants between elephone interviews on that the inservices provided not that the staff were able ing of the education	⟨F €	589	1)		
F 711 SS=D	received in the trainin Physician Visits - Rev CFR(s): 483.30(b)(1): §483.30(b) Physician The physician must-	riew Care/Notes/Order -(3)	F	71	1		
	of care, including med each visit required by section;						
	§483.30(b)(2) Write, s notes at each visit; ar	sign, and date progress ad					
	exception of which may physician-approved it assessment for contra This REQUIREMENT by: Based on interview a facility failed to ensure care needs was adeq psychiatrist for one (Fresidents sampled as to effectively monitor behaviors related to Foundation and	acility policy after an					

led to Resident #1 while unsupervised in his room

# PRINTED: 11/30/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES								
CENTERS FOR MEDICARE & MEDICAID SERVICES C								
FATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED					
			R-C					
	105910	B. WING	11/02/2021					

		105910	B. WING _		11/02/2021
	ROVIDER OR SUPPLIER	CENTED II C		STREET ADDRESS, CITY, STATE, ZIP CODE 9869 SW 152ND STREET	
CORAL K	EEF SUBACUTE CARE	CENTER ELC		MIAMI, FL 33157	
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F711	placing a trash bag o by as a practice. There were medicative receiving the facility at the time of the survey posed i health and safety of a facility.  The Findings Include Record review of the and procedures titled general statement no medications include a activities associated a cativities associated a health procedures titled general statement no medications include a activities associated and hysicians a Physician Assistant, i medicat with the interdisciplin appropriate use, eval standards included: goal of determining it behavioral interventic behavioral interventic behavioral interventic beyochopharmacologi utilized to meet the n G. Psychopharmacologi utilized to meet the n	d suffocated himself by ver his resulting in result of the deficient 17 residents receiving nas and 47 residents medications residing in of this survey. The findings mmediate jeopardy to the ill residents admitted to the different sufference of the survey. The findings mmediate jeopardy to the ill residents admitted to the difference of the survey of	F7	111	

Physician, PA [Physician's Assistant], or NP

### PRINTED: 11/30/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES

DEPARTMENT OF HEALTH AN	FORM APPROVED			
CENTERS FOR MEDICARE &	OMB NO. 0938-0391			
ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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MARE OF PROVIDED OR CURRUED			CERTET ARCONOC CITY CYATE TRACORE	

		105910	B. WING			11/	02/2021
NAME OF PROVIDER OR SUPPLIE	ER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CORAL REEF SUBACUTE C	ADE C	ENTERLIC		9	869 SW 152ND STREET		
CORAL REEF SUBACOTE C	ARC	ENTERLEC		M	NAMI, FL 33157		
PREFIX (EACH DEF	ICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ę	(X5) COMPLETION DATE
rationale and di target symptom interdisciplinary interdisciplinary interdisciplinary intitiating, increas during routine v Procedures Foll health included: establishing apr dosage and mo medications. 5. management pl Procedures Foll 1. Monitors , , any adverse off somnolence or 2. Will monitor f behaviors on a documented as 3. Reviews the physician and the quarterly basis in presence of target of any adverse e 1. will be performe , o reported to the following the physician and the physician and the quarterly basis in presence of target of any adverse e 1. will be performe , o reported to the following the physician and the physician	iner] N iner]	oted: 2 Documents is of the use and identifies  valuates with euse and identifies  valuates with days of  or decreasing dose and  tereafter.  by the Psychiatrist / mental  , assist the facility in  te guidelines for use,  g of , , , , , , , , , , , , , , , , , ,	F	711			

		ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 11/30/2021 M APPROVED D: 0938-0391	
FATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE COMP	(X3) DATE SURVEY COMPLETED	
		105910	B. WING		- 1	R-C 11/02/2021	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
CORAL R	EEF SUBACUTE CARE C	ENTER LLC		9869 SW 152ND STREET MIAMI, FL 33157			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X5) COMPLETION DATE	
F711	and was monitored for the Related to the use of (mg) tablet. There wa Resident 41 was mon behavior such as self. There was no be that he was monitored and for the Further review of the showed that Resident documented as "Afrai monitoring sheet initia monitoring sheet initia Resident 41 had a tot Afraid/Panic. Five out cocurred during the hon 17, 20 PM to 7 and 28. The documer episode noted "Routin Review of the nurses" month of safety of the comment of the shibited by Resident Review of the behavior monitoring shark) for shift (7:00 AM to 7:00 indicating that Resident was no Further review of the Shows of Further review of the shows the for show show the show the shark) for shift (7:00 AM to 7:00 indicating that Resident was no Further review of the for show show the shark) for shift (7:00 AM to 7:00 indicating that Resident was no Further review of the for show show that the shark of the	dicated that Resident # 1 behaviors afraid/panic. 1 milligram is no record to indicate that iltored for any other changes or danger to ehavior record to indicate that indicate to for his diagnosis of e use of behavior monitoring sheets #1 had multiple episodes id/Panic". The behavior ated on indicated al of 9 episodes of of nine different episodes of 7:00 AM to 7:00 PM and 25. Four different inci occurred between the '00 AM, on 27 reted interventions for each ne." progress notes for the showed no record that episodes of #1. or sheets for led date of but the heet showed no record (left and during the day PM) on	F	711			

PM to 7:00 AM shift. The Afraid/Panic behaviors noted to have occurred on , 9, 10, 11, 13, 15, 16, 17, 18, 19, 22, 23, 24, 25 and 29. Review

		ID HUMAN SERVICES MEDICAID SERVICES				FORM APPROVED DMB NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1, ,	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		105910	B. WING			R-C 11/02/2021
	ROVIDER OR SUPPLIER	CENTER LLC	•	STREET ADDRESS, CITY, STATE, ZIF 9869 SW 152ND STREET MIAMI, FL 33157	CODE	
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F711	showed no recorded addressed any of the exhibited by Resident # addressed any of the exhibited by Resident # application of the property of th	is notes for documentation that afraid/panic episodes #1.  1's behavior sheets for ated on) had a total of 17 different ancic during the month of 17 different episodes of between 7:00 AM to 7:00 3, 4, and 5. The intervention cutine OHS Inightly at view of second showed that Resident ifferent episodes of e evening shift (7:00 PM to 7, 12, 13, 14, 17, 19, 128. The documented effer to Nurses Notes.	F	711		

recorded documentation that addressed any of the episodes exhibited by Resident #1.

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		ID HUMAN SERVICES				FOR	M APPROVED	
		MEDICAID SERVICES					0. 0938-0391	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
CORAL R	EEF SUBACUTE CARE O	CENTERLIC		1	9869 SW 152ND STREET			
OOTAL IS	LEI GODAGGTE GARE	PENTEN DEG			MIAMI, FL 33157			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE .	(X5) COMPLETION DATE	
F 711	and record review with (DON), and the Clinic (DON) explained; the nomplete the behavior nurses are the ones to the behavior to the ones to the behavior to the nurse reported and docume nursual for the patient. The clinical records w Plan of care the DON depends about anybody, the cuinclude provide emoit to talk about their feel socialization, provide positive behaviors. No needed.  Review of the investig with the Clinical Regis with t	15 PM, during an interview h the Director of Nursing al Regional Nurse. The nurses on the floor usually remoitoring heets. The hat monitor and document 4A would report each s. Behaviors that are noted are behaviors that are noted are behaviors that are than any behavior that in distress, such as rered discussed related to the lexplained diagnoses of on the patient. For just are planned interventions onal support. Activities, rerested in encouraging them lings. Encourage feedback to reinforce totify MD of changes as upport and interview onal Nurse on at 18 per 18	F	71	1			
	regional nurse had re recording as she inve Clinical Regional Nur observation of the vid reviewed the video re Thursday last week."	leo and reported that she cording on "Tuesday or The report noted that on						
	CNA, [Staff A] went in #] at 4:18 PM. Nurse The Clinical Regional her going in and out of	at 2:54 PM Resident #1's that the residents' room [room [Staff B] was passing meds. Nurse stated: "You can see of rooms." At 4:30 PM the payes Resident # 1's room.						

The video showed that at 4:52 PM meal was delivered to Resident #1's room. His door

### PRINTED: 11/30/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES CE STAT

DEPARTMENT OF HEALTH AN	ID HUMAN SERVICES		FORM APPROVED
CENTERS FOR MEDICARE &	MEDICAID SERVICES		OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
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105910 B. WING \_\_\_\_\_ 11/02/2021

STREET ADDRESS. CITY, STATE, JPP CODE 9869 8W 152ND STREET MIAMI, FL. 33157  MAMI, FL. 33157  MAMI, FL. 33157  MAMI, FL. 33157  MAMI, FL. 33157  TAG  PREPREY TAG  FOR CHAPTER OF U.SC. IDENTIFYING INFORMATION)  F 711  Continued From page 71  remained open the whole time. At 5:21 PM the Nurse (Staff B) went into Resident #1's room. At 5:43 PM the CNAI (Staff A) picked up the tray, (Noted that he ate 100%). At 6:25 PM it appears the door is shult from inside the room. No one checked on the resident or attempted to enter the room from approximately 6:25 PM to 8:15 PM, Staff C), LPN was scheduled to start her shift at 7:00 PM, no indication that she checked on Resident #1 from time her shift started until the CNA called her at around 8:15 PM. At 8:15 PM, the CNA tried to get into the room and noted that the door was closed. The CNA tried to open the door, but it was blocked. Staff A was in the room for a few second, leaves the area. gets the nurse and the crash cart The Regional nurse explained that The CNA had to push the door opened and when he entered, the room heroted Resident #1 seated in his wheelchair, unresponsive with a bag over his and ran to get help. A code was called as well as 911, staff responded to this resident's room where they transferred him to the bed, a backboard was placed, and initiated. Law enforcement and EMTs [Emergency Medical Technician] responded shortly thereafter and pronounced this Resident. The Residents body was transferred to the Medical Examiner's office.  On		105910	B. MING	_		11/4	02/2021
CORAL REEF SUBACUTE CARE CENTER LIC  DAILD  DAILD  SUMMARY STATEMENT OF DEFICIENCIES  (RACH DEFICIENCY MUST BE PRECEDED BY FULL  RESOLATION OF U.SC. IDENTIFYING INFORMATION)  F 711  Continued From page 71  remained open the whole time. At 5:21 PM the  Nurse [Staff B] went into Resident #1's room. At 5:43 PM the CNAI (Staff A) picked up the tray,  (Noted that he ate 100%). At 6:25 PM it appears  the door is shult from inside the room. No one  checked on the resident or attempted to enter the  room from approximatelly 6:25 PM to 8:15 PM,  (Staff C), LPN was scheduled to start her shift at 7:00 PM, no indication that she checked on  Resident #1 from time her shift started until the  CNAI called her at around 8:15 PM. At 8:15 PM,  the CNAI field tog et into the room and noted that  the door was closed. The CNAI tried to open the  door, but it was blocked. Staff A was in the room  for a few second, leaves the area. gets the nurse  and the crash cart The Regional nurse  explained that The CNAI had to push the door  opened and when he entered, the room he noted  Resident #1 seated in his wheelchair,  unresponsive with a bag over his  . The CNAI  stated that he pulled the bag off Resident #1's  and ran to get help. A code was called as  well as 911, staff responded to this resident's  room where they transferred him to the bed, a  backboard was placed, and . initiated. Law  enforcement and EMTs [Emergency Medical  Technician] responded shortly thereafter and  pronounced this Resident. The Residents body  was transferred to the Medical Examiner's office.  On at 10:01 AM, Staff B  Registered Nurse (RN) revealed; she normally  worked with Resident #1 three days a week from  7:00 AM to 7:00 PM. The resident was elect and  oriented times three and communicated his  needs well and normally slept until about 9:00 AM  to 10:00 OM, participated in , and activities	NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
MIAMI, FL. 33157    MAIN, FL. 33157   PREVIOURES PLAN OF CORRECTION   PREFIX   FACILITY AND PREPAY   PREFIX   PREVIOURES PLAN OF CORRECTION SHOULD BE   PRECULATORY OR ISC IDENTIFYING IMPORMATION    PREFIX   TAG   PREVIOURES PLAN OF CORRECTION SHOULD BE   PRECULATORY OR ISC IDENTIFYING IMPORMATION    PREFIX   TAG   PREFIX   PR	CORAL REEF SUBACUTE CARE CENTER LLC				9869 SW 152ND STREET		
DATE OF THE PROPERTY OF DEPTERATIONS (SEACH STREET AND OF CONSECUTION AND SHOULD BE CHARLEST AND OF CONSECUTION AND SHOULD BE CHARLEST AN					MIAMI. FL 33157		
remained open the whole time. At 5:21 PM the Nurse [Staff B] went into Resident #1's room. At 5:43 PM the CNAI [Staff A] picked up the tray, (Noted that he ate 100%). At 6:25 PM it appears the door is shut from inside the room. No one checked on the resident or attempted to enter the room from approximatelly 6:25 PM to 8:15 PM [Staff C]. LPN was scheduled to start her shift at 7:00 PM, no indication that she checked on Resident #1 from time her shift started until the CNA called her at around 8:15 PM. At 8:15 PM, the CNA tried to get into the room and noted that the door was closed. The CNA tried to open the door, but it was blocked. Staff A was in the room for a few second, leaves the area. gets the nurse and the crash cart The Regional nurse explained that The CNA had to push the door opened and when he entered, the room he noted Resident #1 seated in his wheelchair, unresponsive with a bag over his . The CNA stated that he pulled the bag off Resident #1's and ran to get help. A code was called as well as 911, staff responded to this resident's room where they transferred him to the bed, a backboard was placed, and initiated. Law enforcement and EMTs [Emergency Medical Technician] responded shortly thereafter and pronounced this Resident. The Residents body was transferred to the Medical Examiner's office.  On at 10:01 AM, Staff B Registered Nurse (RN) revealed; she normally worked with Resident #1 three days a week from 7:00 AM to 7:00 PM. The resident was east or and oriented times three and communicated his needs well and normally slept until about 9:00 AM to 10:00 OAM, participated in , and activities	PREFIX (EACH DEFICIENC	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ix	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
and liked to come out of the room. Staff B explained that on the day of the incident Resident  PM CMS-3567(2-99 Prevau Versions Ossotete Event ID-ET8W12 Facility ID: 111356 If continuation sheet Page 72 of 89	remained open the w. Nurse (Staff B) went 5:43 PM the CNA [St (Noted that he ate 1 (I the door is shut from checked on the resid room from approxims [Staff C), LPN was st 7:00 PM, no indication of the control of the	hole time. At 5:21 PM the nto Resident #1's room. At aff A] picked up the tray, 0%). At 6:25 PM it appears inside the room. No one ent or attempted to enter the tettle flore. So were all the state of the state of the tettle flore. So were all the state of the tettle flore. The state of the				ion sheet	Page 72 of 89

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND REAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING R-C 105910 R MING 11/02/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9869 SW 152ND STREET CORAL REEF SUBACUTE CARE CENTER LLC MIAMI, FL 33157 SUMMARY STATEMENT OF DEFICIENCIES. PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY F 711 Continued From page 72 F #1 was on isolation precautions due to a ......, ( ). Staff B. RN stated: " I worked from Thursday, .... to ... I monitored for behaviors related to his use of . . . . , we ,, I don't monitored for , fear, or remember him having any behavior. He sometimes would get a little upset with the CNAs. asked that we closed the door, close the window. or vell, don't touch me! Generally, I document if the patient's behavior is constant. Normally, he was easily re-directed ...I did complete the behavior monitoring sheet for the resident on the days that I worked. I filled it out on What I documented was that he had one behavior of . . . . . . . Staff B, RN explained that Resident #1 kept asking about the ( . . . . . . ) treatment. The intervention, during episode was teaching about the reason for the treatment, what was the reason, and why he remained in isolation. Staff B stated that her documentation on the behavior monitoring sheets about the afraid/panic episode was related to the . . . . treatment, that Resident #1 received the treatment and that it was effective. Staff B stated: "I did not document in the nurses notes that the resident was having episode of ...., because I did my action, I did not see him to be desperate, he allowed me to administer his treatment." Staff B reported that the purpose of the behavior monitoring sheet is to follow for a prescribed , medication, and document the episodes related to the behavior, for which the resident is taking the

medication. The intervention was to refer to nurses' notes. Staff B agreed there was no record to explain anything about the resident's behavior. Staff B stated: " It's established that a

### PRINTED: 11/30/2021 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES STA ANE

DELACTIVENT OF MEASURAN DELACTORS				FORM APPROVED
CENTERS FOR MEDICARE &	OMB NO. 0938-0391			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
				R-C
	105910	B. WING		11/02/2021
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE		

NAME OF PROVIDER OR SUPPLIER		- 1	STREET ADDRESS, CITY, STATE, ZIP CODE 9869 SW 152ND STREET			
CORAL REEF SUBACUTE CARE CENTER LLC			MIAMI, FL 33157			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
F 711	Continued From page 73	F 711				
	patient can have at least three small episodes of , we take action if they have a big one. Big ones we would document on the nurses' notes. The purpose of the behavior monitoring sheet is to see if the medication seems effective throughout the month. what the behavior monitoring sheet shows is that the medication is effective. I documented that he had on 37d, and 4th. The one episode could have been something like, "I don't want to shower, I don't know the behavior." Staff B then agreed that the documentation does not reflect the exact nature, or details of the behavior, staff B stated; I also documented no behavior of did not know and could not recall the behavior. Staff B stated; I also documented no behavior to anyone. I did not think that I needed to communicate it to the psychiatrist. We did not monitor him for I did not know he had any or diagnoses of Staff B explained that she would have reacted differently and that she would have reacted differently and that or reject care, or complaint of "Upon discussion of Resident #1's Diagnoses, Staff B mayningthy 1.00 ph of sicussion of Resident #1's Diagnoses, Staff B mayningthy 1.00 ph of sicussion of Resident #1's Diagnoses, Staff B mayningthy 1.00 ph of sicussion of Resident #1's Diagnoses, Staff B mayningthy 1.00 ph of sicussion of Resident #1's Diagnoses, Staff B mayningthy 1.00 ph of sicussion of Resident #1's Diagnoses, Staff B mayningthy 1.00 ph of sicussion of Resident #1's Diagnoses of when I left on that day he remained in his bed. I went in to see him at approximately 7:10 PM he was in his room, he asked we close the door." (Investigative report and interview with The Clinical Regional Nurse on at approximately 5:21 PM),					

		D HUMAN SERVICES MEDICAID SERVICES			FOR	D: 11/30/2021 M APPROVED O: 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL' A. BUILDI	TIPLE CONSTRUCTION ING	(X3) DATI COM	E SURVEY IPLETED
		105910	B. WING		- 1	R-C 1/02/2021
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CORAL RI	EEF SUBACUTE CARE O	ENTER LLC		9869 SW 152ND STREET MIAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	ID PREFI TAG		OULD BE	(X5) COMPLETION DATE
F 711 (F 726) SS=D	above mentioned bet Resident #1's clinical explained that he met discussed residents! a digistments are neec Resident #1. the Psy- ware that Resident # discussion of the mult of afraid/panic noted record, the Psychiatri aware and that the nu- the behavior so him. that the facility staff si partial panic to the behavior exhibited by tell me I would definit nurses usually call me about those episodes have definitely done s	at 10:56 AM ed he did not review the avior monitoring sheets in record. The Psychiatrist with the facility's staff and behaviors and if any ed. When asked about chilatrist reported he was not 1 had any behaviors. Upon piple documented episodes on Resident #1's clinical st reported he was not rises had not communicated The Psychiatrist explained hould have communicated pisodes and any other Resident#1 to him. "If they ply do something. The 2. They did not tell me . Had I known, I would comething, I would have be change the medication taff	F (F 7	726)		
	the appropriate comp provide nursing and re- resident safety and al- practicable physical, a well-being of each res- resident assessments and considering the n	sufficient nursing staff with etencies and skills sets to slated services to assure tain or maintain the highest mental, and, ident, as determined by and individual plans of care				

accordance with the facility assessment required

		ID HUMAN SERVICES MEDICAID SERVICES					RM APPROVED IO. 0938-0391
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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY MPLETED
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		105910	B. WING	_		111	1/02/2021
NAME OF P	ROVIDER OR SUPPLIER			Г	STREET ADDRESS, CITY, STATE, ZIP CODE		
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CORAL R	EEF SUBACUTE CARE	CENTER LLC			MIAMI, FL 33157		
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TAG	REGULATORY OR I	LSC IDENTIFYING INFÓRMATION)	TAG		CROSS-REFERENCED TO THE APPRO	RIATE	DATE
					DEFICIENCY)		
{F 726}	Continued From page	e 75	{F 7	726	3}		
			1				
	\$483,35(a)(3) The fac	cility must ensure that					
		the specific competencies					
		ary to care for residents'					
	needs, as identified ti						
		scribed in the plan of care.					
			İ				
	§483.35(a)(4) Providi	ng care includes but is not					
		evaluating, planning and					
		it care plans and responding					
	to resident's needs.						
	§483.35(c) Proficienc	v of nurse aides.					
		ure that nurse aides are able					
	to demonstrate comp	etency in skills and					
	techniques necessary	y to care for residents'					
	needs, as identified the	hrough resident					
	assessments, and de	scribed in the plan of care.					
	This REQUIREMENT	is not met as evidenced					
	by:						
		iews and interviews, the					
		e staff were competent in					
		are and supervision of					
		behavioral care needs. As					
		lity's failure to ensure staff					
	received and impleme						
		ent prevention, documenting,					
		ors and communicating					
		chiatrist. Resident #1 was					
		resident cared for by staff					
		sh language. Resident #1's					
	diagnoses of , ,						
	well as episodes of a						
		unrecognized, leading to his					
		ted harm. As a result of the					
		ctice one (Resident #1) out					
	of 10 residents samp	led Resident #1 suffocated					-

himself by placing a plastic trash bag over his

		ID HUMAN SERVICES						APPROVED
		MEDICAID SERVICES						. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDII		STRUCTION		(X3) DATE COMP	LETED
		105910	B. WING_				11/	02/2021
NAME OF PR	ROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CO	DE		
CODAL DI	EEE SUDACHTE CADE (	CENTED I I C		9869 SV	W 152ND STREET			
CORAL RI	EEF SUBACUTE CARE (	JENIER ELC		MIAMI,	FL 33157			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BI		(X5) COMPLETION DATE
{F 726}	Continued From page	e 76	{F 7	26}				
	The findings included	<b>:</b>						
	dated revelopment of the state	wed by qualified nursing ne if needs can be met at the bed; "Our facility's resident thinic backgrounds, (ex: acks) Staff speaks bole. The season of the						
	consistent assignmer meaningful relationsh families All personi	<ol> <li>"Direct care staff is given nts to promote and establish ips with the residents and nel training competencies re. Including staff managers, and volunteers.</li> </ol>						
	personnel. Evaluation annually completed for	d for all newly employed as and competencies are or all direct care staff mpetencies are completed f.						
	During an interview w	ith the Director of Nursing						

(DON) on ... at 2:00 PM, the DON

EPARTMENT OF HEALTH AND HUMAN SERVICES ENTERS FOR MEDICARE & MEDICAID SERVICES						
TEMENT OF DEFICIENCIES O PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED			
	105910	B. WING	R-C 11/02/2021			

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE 9869 SW 152ND STREET MIAMI, FL 33157	STREET ADDRESS, CITY, STA	105910 B. WING		,	11/02/2021
CORAL REEF SUBACUTE CARE CENTER LLC 9869 SW 152ND STREET MIAMI, FL 33157					
CORAL REEF SUBACUTE CARE CENTER LLC MIAMI, FL 33157			PROVIDER OR SUPPLIER		
	1	CENTER LLC	REEF SUBACUTE CARE C	1	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION		,			
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP	PREFIX (EACH CORRECT TAG CROSS-REFEREN	CY MUST BE PRECEDED BY FULL PREFI	(EACH DEFICIENCY	FIX (EACH CORRECTIVE ACTION SHOULD BE G CROSS-REFERENCED TO THE APPROPRIAT	(X5) COMPLETION DATE
explained, after the incident, she initiated in service training for staff on the topic of and accident prevention. "Staff have begun to have education on mental illness with emphasis on and reporting remains and reporting remains and reporting and reporting remains and reporting and reporting remains and reporting and reported and reporting	(F 726)	ncident, she initiated in aff on the topic of the topic o	explained, after the in service training for sist and accidid begun to have educatemphasis on  During an interview at  Human Resources M. 3:39 PM, review of en record to indicate staf training or competence mental health, diagnoses of  Record Review of the year showed monitoridiagnoses of  Record Review of the staff in the facility see the calendar did not show informed care.  During an interview or the DON and the Soci called the staff and for taking them prior to a medication was routin whether or not he disg of The rurs for meds as an episoc the Social Services A policy for and the scalility have the social Services A policy for added to the scope of and, the facility have the a new p admissions Social Seimid a new p admissions Social Seimid or ear	726}	

### PRINTED: 11/30/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES STA

PORT ACTIVITIES OF THE PROPERTY OF THE PORT OF THE POR						
CENTERS FOR MEDICARE & I	MEDICAID SERVICES		OMB NO. 0938-039			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED			
			R-C			
	105910	B. WING	11/02/2021			

		105910	B. WING	_		11/	02/2021
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
				١,	9869 SW 152ND STREET		
CORAL R	EEF SUBACUTE CARE C	ENTER LLC			MIAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC (DENTIFYING INFORMATION)	ID PREFI	ıx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	F	(X5) COMPLETION DATE
ING		,	1710		DEFICIENCY)		
{F 726}	Continued From page	78	{F 7	726	}		
	their effect on residen	it's and behavior. At					
	the time that Residen	t #1 was admitted to the					
	facility, those question	ns were not asked. The					
	DON and the Social S	Services Assistant revealed					
	that the facility did not	t ask about Resident #1's					
	life experiences and o	did not ask if the resident					
	had any life	experiences and added					
		ared for him did not know					
	about any past	. Resident # . , have					
	experienced.	-					
	·						
	Record review of Res	ident #1's Behavior					
	Monitoring Sheets for	the months of					
	and	, indicated that					
	Resident # 1 was mor	nitored for the behaviors					
	afraid/panic. Related	to the use of					
	1mg tablet. No recor	d to indicate that Resident					
	#1 was not monitored	for any other behavior such					
	as changes or o	danger to self. There were					
	no behavior records to	o indicate that he was					
	monitored for his diag	nosis of for the					
	use of ,	or for his diagnosis of					
	Review of the behavio	or monitoring sheets showed					
		ple episodes documented					
		of Resident #1					
		des of Afraid/Panic. Five out					
		des occurred between the					
	hours of 7:00 AM to 7	:00 PM, on , 17,					
	20, and 25. Four diff	erent episodes of					
		between 7:00 PM to 7:00					
		7 and 28. Interventions for					
		Routine." The nursing notes					
	for, showed no re	ecord that addressed any of					
	the episodes of	, exhibited by Resident #1.					
	During the Month of	(Initiated on					
	), The behav	ior monitoring sheet showed					

		ID HUMAN SERVICES						APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES						. 0938-0391
	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		STRUCTION		(X3) DATE : COMPI	.ETED
		105910	B. WING			ļ	R-	02/2021
NAME OF PE	ROVIDER OR SUPPLIER		_	STREE	T ADDRESS, CITY, STATE, ZIP CODE			
				9869 S	W 152ND STREET			
CORAL RI	EEF SUBACUTE CARE (	CENTER LLC		MIAM	I, FL 33157			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
(F 726)	monitored during that behavior monitoring r #1 had 15 different ej during the evening s† Arfaid/Panic behavior 10, 11, 13, 15, 16, 17 29. The Nurses Prog showed no record the episodes of afraid/pa For 17 different episodes month. Four out 17 d Arfaid/Panic occurred control of the showed that Residen different episodes of Arfaid/Panic Showed that Residen different episodes of cevening shift (7PM-7, noted "Refer to Nurse behavior occurred on 17, 19, 20, 21, 24, 26 Nurses Progress Not showed that Residen the shibited by Residen The behavior monitor showed that Residen that Residen that Residen the showed that Residen the showed that Residen the control of the shibited by Residen The behavior monitor showed that Residen three episodes. Two	for and And ArPM) of an and ArAM - 7PM) of an avior "Artaid/Panic" was not time. Further review of the ecord showed that Resident bisodes of Afraid/Panic it (7PM-7AM). The accourred on 9, 18, 19, 22, 23, 24, 25 and ress Notes for 1 addressed any of the inc exhibited by Resident #1's had a total of of Afraid/Panic during the ifferent episodes of between 7 AM - 7 PM: on d5. The intervention noted to the control of the individual of the indivi	(F 7	(26)				
	and on the	ne day of his episode of Afraid/Panic						

between 7PM - 7 AM on

Interventions for each episode noted "Routine

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
TATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION	(X3) DATE SURV COMPLETED	
		105910	B. WING			1	02/2021
	ROVIDER OR SUPPLIER	ENTER LLC	•		STREET ADDRESS. CITY, STATE, ZIP CODE 9869 SW 152ND STREET MIAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 726}	month of , sh addressed any of the Resident #1.  On at 8.4 Supervisor, Staff I red to the behavior mon a routine medication the behavior mon a routine medication was effect an episode of behavior such as trying et up from the whore such as trying et up from the whore the medications and the episode happened is the intervention for who two writing is to call the evaluation of the residence of the residence of the reported that she doe Behavior Monitoring a Staff I state to represent no episos shift. Staff I reported that she does not behavior.  Interview on speaking Certified Nu A revealed he worked year and floated to a Staff A reported that #1 on Friday, the	progress notes for the owed no record that episodes exhibited by perisodes exhibited by the proposed of the pr	(F.7	726	3)		

liked to stay in his room alone with the door

		D HUMAN SERVICES					M APPROVED	
CENTER	S FOR MEDICARE &	MEDICAID SERVICES	_			OMB NO	0. 0938-0391	
	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION	1	PLETED	
		105910	B. WING				-C 02/2021	
ALLAND OF DE	ROVIDER OR SUPPLIER	1		Ξ	STREET ADDRESS, CITY, STATE, ZIP CODE	111/	02/2021	
WANE OF F	KOVIDER OR SUPPLIER			1				
CORAL RI	EEF SUBACUTE CARE O	ENTER LLC			9869 SW 152ND STREET MIAMI, FL 33157			
arn m	CIBMANDV CT	ATEMENT OF DEFICIENCIES	1D	_	PROVIDER'S PLAN OF CORRECTION		0071	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD B	(EACH CORRECTIVE ACTION SHOULD BE COMPLE CROSS-REFERENCED TO THE APPROPRIATE DATE		
{F 726}	Continued From page	. 81	{F 7	726	31			
(, , , , , , ,	, ,		ν.	20	"			
		ssistance to go to bathroom						
		precautions. Staff A, CNA						
		e for that weekend; on						
		worked a double shift from						
		and from 3:00 PM to 11:30						
	PM. He continued or	Saturday to AM to 11:30 PM. Staff A						
	reported that on the d							
		e from break which						
		8:30 PM. Staff A stated that						
		ced that Resident #1's door						
		ne pushed the door. Staff A						
		the resident may have						
		something. Staff A: " When						
		oor, I noticed the resident						
		ir with a plastic bag on his						
		r was locked. He normally						
		ers, one on each side of his						
		inside of it. Once I opened						
	the door, I noticed the							
		threw it on the floor and						
		or nurse was on the hallway.						
		ash cart, she called code						
		transferred the resident from						
		chair, they initiated the						
		rrived The police arrived						
		I could not leave the						
		letective interviewed me.					Control	
	During the interview,							
		es was aggressive and had						
		g care such as a haircut and						
		aff A reported that he had to						
		and he allowed him to						
		orted that not that long ago,						
		sident #1 would sometimes						
		staff and one time Resident						
		and threw it at him. Staff A						

reported that he reported the behavior to the floor nurse and asked the nurse to come to the room

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				FORM	APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES					0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION		LETED
		105910	B. WING				-C 02/2021
NAME OF P	ROVIDER OR SUPPLIER		_	Г	STREET ADDRESS, CITY, STATE, ZIP CODE		
					9869 SW 152ND STREET		
CORAL R	EEF SUBACUTE CARE O	ENTER LLC			MIAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE
(F 726)	and help him translate that he (Staff A) here that there was no nee Resident #1 understo with the Clinical Regia approximately 2:30 P regional nurse had re recording as she inve Clinical Regional Nurobservation of the video re recording as she inve Clinical Regional Nurobservation of the video re Thursday last week." Saturday a CNA, [Staff A] went in #] at 4:18 PM. Nurse The Clinical Regional her going in and out of friend [Resident #4] le The video showed the video re remained open the will Nurse [Staff B] went it will be a should be considered that he are 10 the door is shut from checked on the reside orm from approxima [Staff C]. LPN was sc 7:00 PM, no indication Resident #1 from time CNA called her at a rothe CNA first door was closed. Resident #1 from time CNA called her at a rothe CNA twas block for the was block for the w	a and explain to Resident #1 to take care of him, and d to be aggressive and od and even apologized, pative report and interview onal Nurse on at M revealed, the Clinical viewed the facility's video stigated the event. The se documented her eo and reported that she cording on "Tuesday or The report noted that on 12:54 PM Resident #1's to the residents' room [room [Staff B] was passing meds. Nurse stated: "You can see if rooms." At 4:30 PM the saves Resident #1's room. At at 4:52 PM the hoto Resident #1's room. At at 4:52 PM the note Resident #1's room. At af Apicked up the tray, 0%). At 6:25 PM it appears inside the room. No one end of a the fault of the room one of the tray of the room. The most of the period of the room. No one end of a the fault of the the the side of the the the to the side of the the the the of the the the the side of the the the the the the side of the	{F 7	7726	53		

and the crash cart... The Regional nurse explained that The CNA had to push the door

CENTERS FOR MEDICARE &			D HUMAN SERVICES					APPROVED
IDENTIFICATION NUMBER:  105910    STREET ADDRESS, CITY, STATE, ZIP CODE				1				
INMEC OF PROVIDER OR SUPPLIER  CORAL REEF SUBACUTE CARE CENTER LLC  SUBMINATY STATEMENT OF DEFICIENCES  (EACH DEFICIENCY MUST BE PRECEDED BY PULL TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  (F 726)  Continued From page 83 opened and when he entered, the room he noted  Resident #1 seated in his wheelchair,  unresponsive with a bag over his The CNA  stated that he puiled the bag off Resident #1's  and ran to get help. A code was called as  well as 911, staff responded to this resident's  room where they transferred him to the bed, a  backboard was placed, and initiated. Law  enforcement and EMTs responded shortly  thereafter and pronounced this Resident. The  Residents body was transferred to the Medical  Examiner's office.  Onal 10:01 AM, with Spanish  speaking Registered Nurse (RN), Staff B  revealed; she normally worked with Resident #1  three days a week from 7:00 AM to 7:00 PM. The  resident was aleft and oriented times three and  communicated his needs well. Staff B, RN was not able to  explain why the Medication Administration  Records (MAR) indicated zero for , level the  entire month of and Staff B  insisted that the resident did not have Y Those  last three days 's Staff B, RN stated.' I  worked from Thursday, to salturday							COMP	LETED
CORAL REEF SUBACUTE CARE CENTER LLC    SUMMARY STATEMENT OF DEFICIENCIES   REACH DEFICIENCY MUST are PRECEDED BY FULL   PREFIX   REQUILATION Y OR US. DENTIFYING INFORMATION    PREFIX   TAG   PROVIDER'S PLAN OF CORRECTION (REACH CORRECTIVE ACTION SHOULD BE ORDER TO AND CORRECTION (REACH CORRECTIVE ACTION SHOULD BE ORDER TO AND CORRECTION SHOULD BE ORDER TO AND CORRECTION SHOULD BE ORDER TO AND CORRECTION (REACH CORRECTIVE ACTION SHOULD BE ORDER TO AND CORRECTION SHOULD BE ORDER			105910	B. WING				
CORAL REEF SUBACUTE CARE CENTER LLC  (PA) ID  SUMAMARY STATEMENT OF DEFICIENCIES  (PACH DEPICENCY MUST BE PRECEDED BY FULL RECOLATIONY OR LSC IDENTIFYING INFORMATION)  (F 726)  Continued From page 83 opened and when he entered, the room he noted Resident #1 seated in his wheelchair, unresponsive with a bag over his The CNA stated that he pulled the bag off Resident #1*s and ran to get help. A code was called as well as 911, staff responded to this resident's room where they transferred him to the bed, a backboard was placed, and initiated. Law enforcement and EMTs responded shortly thereafter and pronounced this Resident. The Residents body was transferred to the Medical Examiner's office.  On at 10:01 AM, with Spanish speaking Registered Nurse (RN), Staff B revealed; she normally worked with Resident #1 three days a week from 7:00 AM to 7:00 FM. The resident was alert and oriented times three and communicated his needs well. Staff B, RN was asked about Resident #1'. Staff B, RN was asked about Resident #1'. Staff B, RN was asked about Resident #1'. Staff B, RN was asked about Resident #1' had, at times; "I remember he did at some point take medications, and communicated his needs well. Staff B, RN was asked about Resident #1' had, at times; "I remember he did at some point take medications, and Staff B, insisted that the resident did not have the last times she cared for him (Thursday, to Saturday ). "Those last three days he did not have 'Staff B explained that on the day of the incident Resident #1' was on isolation precautions due to a throat in the period of to Saturday in monitored for behaviors related to his use of to Saturday in monitored for behaviors related to his use of to Saturday to Saturday	NAME OF PR	ROVIDER OR SUPPLIER			1			
DANID PREFIX (EACH DEFICIENCY NUTS TEATHERN TO F DEFICIENCIES (EACH DEFICIENCY NUTS TEATHERN TO F DEFICIENCY STATE BY RECOLATORY OR IS CIDENTIFYING INFORMATION)  (F 726)  Continued From page 83 opened and when he entered, the room he noted Resident #1 seated in his wheelchair, unresponsive with a bag over his The CNA stated that he pulled the bag off Resident #1 stated the bag off Resident #1 stated that he pulled the bag off Resident #1 stated that he pulled the bag off Resident #1 stated that he pulled the bag off Resident #1 stated that he pulled resident #1 stated that he pulled resident #1 stated shortly thereafter and pronounced this Resident #1 three days a week from 7:00 AM to 7:00 FM. The Residents body was transferred to the Medical Examiner's office.  On , at 10:01 AM, with Spanish speaking Registered Nurse (RN), Staff B revealed; she normally worked with Resident #1 three days a week from 7:00 AM to 7:00 FM. The resident was allert and oriented times three and communicated his needs well. Staff B, RN was asked about Resident #1', Staff B, RN was asked about Resident #1', Staff B, RN was asked about Resident #1', Staff B, RN was not able to explain wity the Medication Administration Records (MAR) incliented zero for level the entire month of and Staff B insisted that the resident did not have the last times she cared for him (Thursday, to Saturday	CODAL DI	TEE CURACUTE CARE	SENTED LLC			9869 SW 152ND STREET		
FREENE TAG RECOLATORY OR US CIDENTIFYING INFORMATION)  (F 726)  Continued From page 83 opened and when he entered, the room he noted Resident #1 seated in his wheelchair, unresponsive with a bag over his The CNA stated that he pulled the bag off Resident #1 stated the bag off Resident #1 shaded in his wheelchair, or own where they transferred him to the bed, a backboard was placed, and initiated. Law enforcement and EMTs responded to this resident's room where they transferred him to the bed, a backboard was placed, and initiated. Law enforcement and EMTs responded shortly thereafter and pronounced this Resident. The Residents body was transferred to the Medical Examiner's office.  On , at 10:01 AM, with Spanish speaking Registered Nurse (RN), Staff B revealed; she normally worked with Resident #1 three days a week from 7:00 AM to 7:00 PM. The resident was alert and oriented times three and communicated his needs well. Staff B, RN was asked about Resident #1', Staff B, RN acknowledged that Resident #1 had, at times; "I remember he did at some point take medications, and For about three days" Staff B, RN was not able to explain wity the Medication Administration Records (MAR) indicated zero for, level the entire month of and Staff B insisted that the resident did not have, the last times she cared for him (Thursday, to Saturday	CURAL RI				L	,		,
opened and when he entered, the room he noted Rosident #1 seated in his wheelchair, unresponsive with a bag over his The CNA stated that he pulled the bag off Resident #1's and ran to get help. A code was called as well as 911, staff responded to this resident's room where they transferred him to the bed, a backboard was placed, and Initiated. Law enforcement and EMTs responded shortly thereafter and pronounced this Resident. The Residents body was transferred to the Medical Examiner's office.  Onat 10:01 AM, with Spanish speaking Registered Nurse (RN), Staff B revealed; she normally worked with Resident #1 three days a week from 7:00 AM to 7:00 FM. The resident was alert and oriented times three and communicated his needs well. Staff B, RN was asked about Resident #1 had, at times: I remember he did at some point take medications, and For about three days' Staff B, RN was not three days' Staff B, RN and son table to explain why the Medication Administration Records (MAR) indicated zero for, level the entire month of and Staff B insisted that the resident did not have the last times she cared for him (Thursday, to Saturday Staff B explained that on the day of the incident Resident #1 was on isolation precautions due to a	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE				
	{F 726}	opened and when he Resident #1 seate with a later that he pulled it and ran to get he well as \$11, staff resp. com where they tran backboard was place enforcement and EM thereafter and pronou. Residents body was 1 Examiner's office.  On speaking Registered revealed; she normall three days a week fresident was alert and communicated his ne asked about Residen acknowledged that Rimes; Il remember he medications, asked about three days" Ste explain why the Medi Records (MAR) indicentire month of insisted that the resid last times she cared for insisted that the resident was he cared for the staff of the staff was a last three days be cared for the staff was a last three staff was a last three staff was a last three staff was not solation profit of the staff was no isolation profit of the staff of the st	entered, the room he noted this wheelchair, ago over his The CNA he bag off Resident #1's elp. A code was called as onded to this resident's sferred him to the bed, a d, and initiated. Law Is responded shortly unced this Resident. The ransferred to the Medical strength of the manner of the m	₹F	726			

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 11/30/2021 M APPROVED D: 0938-0391
STATEMENT OF DEFICIENCIES UND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		105910	B. WING			1	(-C /02/2021
NAME OF P	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
CORAL R	EEF SUBACUTE CARE (	CENTER LLC			69 SW 152ND STREET IAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 726}			{F 7	26}			
	remember him having						
		a little upset with the CNAs,					
		the door, close the window,					
		el Generally, I document if					
	was easily re-directed	is constant. Normally, he					
		sheet for the resident on the					
	days that I worked.						
		day that he					
	What I documented v						
	behavior of"	Staff B, RN explained that					
	Resident #1 kept ask						
	( ) treatme	ent. The intervention, during					
	the , episode w	as teaching about the					
	reason for the treatme	ent, what was the reason,					
		l in isolation. Staff B stated					
	that her documentation						
		out the afraid/panic episode					
	was related to the						
		the treatment and that it					
		stated: "I did not document					
		at the resident was having					
		ecause I did my action, I did sperate, he allowed me to					
		tment." Staff B reported that					
		havior monitoring sheet is to					
		d medication,					
	and document the ep						
		e resident is taking the					
		vention was to refer to					
	nurses' notes. Staff B	agreed there was no					
	record to explain any	thing about the resident's					
	or behavior. S	taff B stated: " It's					
	established that a pal	lient can have at least three					
	small episodes of .	. , , we take action if they					
	have a big one. Big of	ones we would document on					

the nurses' notes. The purpose of the behavior monitoring sheet is to see if the medication seems effective throughout the month ...what the

		ID HUMAN SERVICES					M APPROVED
		MEDICAID SERVICES	T				0. 0938-0391
	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		E CONSTRUCTION	1	PLETED
		105910	B. WING				-C 02/2021
NAME OF PE	ROVIDER OR SUPPLIER		_		STREET ADDRESS, CITY, STATE, ZIP CODE		
				١,	9869 SW 152ND STREET		
CORAL RI	EEF SUBACUTE CARE O	CENTER LLC			MIAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
{F 726}	medication is effective on	heet shows is that the  I documented that had  3rd, and 4th. The one een something like, "I don't 'I know the behavior." Staff e documentation does not e, or details of the behavior, could not recall the detail the documented no 10th, 11th, 16th, 'When I noticed the bort to anyone. I did not think nunicate it to the out to anyone. I did not think nunicate it to the out monitor him for know he had any gnoses of With "Staff B explained that ed differently and that ery dangerous, levels of 's can change and crisis. "On that day he tot seem depressed. He did plain of "Upon It #I's diagnoses, Staff B issed that he had diagnosis I left on that day he I went in to see him at M he was in his room, he oor." (Note: The di interview with the Clinical the room at M).	₹F:	726			
	On at 10:	56 AM, the Psychiatrist					

reported he did not review the above-mentioned behavior monitoring sheets in Resident #1's

DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES					D: 11/30/2021
CENTER	S FOR MEDICARE &	MEDICAID SERVICES					0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION		(X3) DATE COMP	SURVEY
						R	-C
		105910	B. WING		_	11/	02/2021
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	STATE, ZIP CODE		
CODAL DI	EEF SUBACUTE CARE O	CENTED II C		9869 SW 152ND STREET			
CORAL K	EF SOBACOTE CARE C	ZENTER CEC		MIAMI, FL 33157			·····
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	IX (EACH CORRE	R'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BI ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 726}			{F 7	726}			
		xplained that he met with					
		ssed residents' behavior					
		ts needed. When asked, the he was not aware that					
		behaviors. Upon discussion					
		ed episodes of afraid/panic					
	noted on Resident #1						
		he was not aware; the					
		unicate the behaviors to					
	him, and the facility's						
		,, afraid/panic episodes and					
		chibited by Resident#1. The					
		'if they told me I would ng. The nurses usually call					
		me about those episodes.					
	Had I known, I would						
		ve gone to see him, maybe					
	change the medicatio						ļ
{F 867}	QAPI/QAA Improvem	ent Activities	{F 8	367}			
SS=D	CFR(s): 483.75(g)(2)	(ii)					
	§483.75(g) Quality as	ssessment and assurance.					
	§483.75(g)(2) The qu	ality assessment and					
	assurance committee	must:					Ė
	(ii) Develop and imple	ement appropriate plans of					
		tified quality deficiencies;					
		is not met as evidenced					
	by:						
		viewed and interviews, the nstrate an effective plans of					
		ted to correct identified					
		problem-prone areas,					É
		uracy of assessments,					
		elementation of care plan,					

quality of care, accidents hazards/supervision and quality assurance and performance improvement (QAPI) as evidenced by repeated deficient

	MENT OF HEALTH AN						M APPROVED
	RS FOR MEDICARE & I			_			0. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		PLE CONSTRUCTION		PLETED
	I	105910	B. WING				t-C
ALLAND OF D	ROVIDER OR SUPPLIER	100010		Ξ	STREET ADDRESS, CITY, STATE, ZIP CODE	1 11)	02/2021
NAME OF PI	YOUNDER OR SOMMER			1			
CORAL R	EEF SUBACUTE CARE C	ENTER LLC			9869 SW 152ND STREET MIAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	ΊX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 867}	practice found in thes	e 87 se areas during consecutive rence F600, F641, F656,	{F &	367	7}		
	The findings included	:					
	revealed, during the a man and during the exit date practice was cited reliced	). Accuracy of Assessments alop and implement a plan (F656). Accidents, p. Devices related to facility the resident environment cident hazards as is sident receives adequate stive devices to prevent failure to ensure an rance and Performance					
	(NHA) on NHA reported the faci Assessment and Assimet at least once a m of every month. The Director of Nursing (C the Assistant Director Medical Records part Nurses (RN) Supervis all department heads Director and the Houst the last annual survey.	urance (QAA) program that nonth; on the third Thursday participants included the DON), the Medical Director,					

of the QAPI committee.

		ID HUMAN SERVICES			FORM	D: 11/30/2021 M APPROVED D: 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		105910	B. WING			I-C (02/2021
NAME OF P	ROVIDER OR SUPPLIER		- 1	TREET ADDRESS, CITY, STATE, ZIP CODE		
CORAL R	EEF SUBACUTE CARE O	ENTER LLC	1	869 SW 152ND STREET MAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
(F 867)	During the interview, QAPI plan that met re MHA explained, YWe I to identify systemic is in the committee bring been identified within Services Director for issue he addressed in Then discuss a possil Nursing (DON) documbrought to the meetin from the last meeting intervention was put i the start of the next C we had a QAPI meetin MHA described the cquality deficiency rela and with communicat agencies. (Referred and with communicat agencies. (Referred and subsequent compuneys). The NHA st repeated deficient prof staff lack of adhere procedures, therefore education." The NHA	the NHA did not present a guilatory requirements. The nave a system that we use sues in our facility, everyone 5 up any riscuss that has their department, the Social example, will express if any sight require more attention, ble plan, the Director of nents everything that is g. She types up the report report and whatever nto place are discussed at NAPI meeting. The last time ng was on The wrentities had identified ted to COVID-19 ion / expectations from state only to deficient practices or Health Care during last annual survey Jaint / Control ated: "We understand that cities might be an indication	{F 867}			

DDINTED: 11/30/2021

		ID HUMAN SERVICES				FOR	M APPROVED
	OF DEFICIENCIES	MEDICAID SERVICES	400 5000	was en			D. 0938-0391
	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI		LE CONSTRUCTION		SURVEY
			A. BUILUI	MG			2-C
		105910	B. WING				/02/2021
NAME OF P	ROVIDER OR SUPPLIER			Г	STREET ADDRESS, CITY, STATE, ZIP CODE		OMIZON !
				1	9869 SW 152ND STREET		
CORAL R	EEF SUBACUTE CARE (	CENTER LLC			MIAMI, FL 33157		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID.	_	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		COMPLETION DATE
{F 000}	INITIAL COMMENTS		{F C	000	)		
		vey for complaint numbers 1013886,was conducted on					
		rough , at					
	Coral Reef Subacute						
	allegations for comple	aint number 2021013844					
		thout deficient practice. The					
		aint number 2021013886					
		th deficient practice. The					
		npliance with 42 CFR 483, ng Term Care Facilities.					
	requirements for Eor	ig remi care i acintea.					
	On .	, it was determined the					
	findings of the survey	posed immediate jeopardy					
		ety of the residents admitted					
	to the facility.						
	immediate Jeopardy immediate corrective	means, a situation in which					
		's noncompliance with one					
	or more requirements						
		ation has caused, or is likely					
	to cause, serious inju						
	to an individual	receiving care in a facility.					
	The Immediate Jeopa	ardy started on ,					
	The facility's Adminis	trator, Director of Nursing					
		Consultant were notified of					
	the immediate Jeopa						
		nediate Jeopardy templates					
	were provided.						
		and Substandard Quality of					
	Care was identified a						
	F 600, Scope and Se and Neglect	verity (J) - Freedom from					
		verity (J) - Development and					

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

(X6) DATE /2021

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

Electronically Signed

program participation.

		ID HUMAN SERVICES MEDICAID SERVICES					APPROVED 0.0938-0391
STATEMENT C	S FOR MEDICARE & I OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE	
		105910	B. WING				-C 02/2021
NAME OF PR	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
CORAL RI	EEF SUBACUTE CARE C	ENTER LLC		1	9869 SW 152ND STREET MIAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 000}	Continued From page Implementation of Ca F 689, Scope and Ser Hazards, Supervision	re Plans verity (J) - Free of Accident	{F (	000	3		
	The facility census at 132.	the time of the survey was					
	A partial extended sur	rvey was conducted on					
	The facility's Immedia was submitted on	te Jeopardy removal plan					
	The Immediate Jeopa of the exit on	ardy was ongoing at the time					
	Removal Plan was ve through record review	cility's Immediate Jeopardy riffled by the survey team is and interviews. It was ity completed in-services for related to the Immediate is.					
	of the facility's correct						
	689 were lowered to a	ty for F 600, F 656 and F a (D) for No actual harm with aan minimal harm that is not s of					

The following is a description of the

		ID HUMAN SERVICES MEDICAID SERVICES					APPROVED 0. 0938-0391
ATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		105910	B. WING			11/	02/2021
NAME OF P	ROVIDER OR SUPPLIER			8	TREET ADDRESS, CITY, STATE, ZIP CODE		
CODAL DI	EEF SUBACUTE CARE O	PENTERLIC		9	869 SW 152ND STREET		
CORAL	EEF SOUNCOTE CARE C	ZENTER EEC		N	MAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 600} SS≖D	Free from and CFR(s): 483.12(a)(1)	Neglect	{ <b>F</b> €	(00			
	and includes but is not lim corporal punishment, any physical or chem treat the resident's mire than the same than the s	right to be free from tion of resident property, effined in this subpart. This itted to freedom from involuntary and ical not required to adical symptoms.  y must- everbal, mental, or rail punishment, or is not met as evidenced observations and records			F600 Resident #1 no longer resides in the facility Administrator/designee educated facilistaff on and Neglect, informed care and behavioral health v emphasis on monitoring residents prescribed and medications and identifying possible ractors and changes in and behavior as well as side effects. Residents with a diagnosis of have the potential to be affected. The facility has conducted an audit of current residents with a diagnosis of and who are prescribed and medication to ensure they have an	rith isk and	

related to the Immediate

effective plan of care in conjunction with

		ID HUMAN SERVICES MEDICAID SERVICES					M APPROVED 0. 0938-0391
TATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDE		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		105910	B. WING				t-C (02/2021
NAME OF P	ROVIDER OR SUPPLIER			S'	TREET ADDRESS, CITY, STATE, ZIP CODE		
				98	869 SW 152ND STREET		
CORAL R	EEF SUBACUTE CARE O	CENTER LLC		М	HAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE .	(X5) COMPLETION DATE
{F 600}	Jeopardy deficiencies The scope and sever of the facility's correct The immediate jeopa- memoved on The scope and sever to a (D) for No actual more than minimal ha- jeopardy as of The Findings Includee Record review of the Record review of the Record review of the Record review of the Genies The Findings Includee Record review of the policy of the facility from physical or ment neglect is goods and services in property Neglect is og goods and services or property Neglect is og goods and services or property Neglect is og goods and services are planning, and medication services are planning, and for property Record review of the procedures revealed of Policy noted; any drug that affects with process and be physician extenders Nurse Practitionery w medications appropri-	ity was lowered as a result to was cloons implemented.  rdy was determined to be  ity for F 600 were lowered  harm with a potential for  arm that is not immediate  it is possible to be  facility's policy  are protect all residents  tal involuntary  misappropriation of personal  fefined as failure to provide  ecessary to avoid physical  a, or mental illness,  included: The assessment,  onitoring of residents with  which might lead to conflict  facility's policies and  the (undated) policy Name:  ion. The General Statement  medications include  autivities associated  avoir, including  and  so of drugs. Physicians and  (Ex. Physician Assistant,  ill use  murse to ensure appropriate	{F 6	00}	implementing policies and procedures identify risk factors and change in and behavior as well as side effects are effectiveness of these medications an ensure behavior monitoring sheets are place and reflect the behaviors of the resident and that side effects are monitored. Social services and nursing staff was educated on a one-to-one basis by Administrator/DON on informe care including a newly added questionnaire regarding. Policies: Resident Neglect an Policy, Informed Care, Behavioral Health Services, Medication, Clinical Protocol, Care Plans, Comprehensive Person-Centered Administrator/designee educated facilistaff on a one-to-one basis including staff on a one-to-one basis including Licensed Nursing Staff, and Social Services regarding behavioral health emphasis on monitoring residents prescribed and medications and identifying possible redicators and changes in saide effects and behavior as well as side effects and efficacy of medication. Administrator/designee educated all ston a one-to-one basis regarding and helavior as well as side effects and efficacy of medication. Administrator/designee educated all ston a one-to-one basis regarding and helavior as well as side effects and efficacy of medication. Administrator/designee educated all ston a one-to-one basis regarding and helavior as well as side effects and estimated the support of the properties	nd d d to in in ded d d d d d d d d d d d d d d d d d	

Standards included:

monitoring residents with diagnosis of

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		105910	B. WING		R-C 11/02/2021
	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 9869 SW 152ND STREET	11102/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI  (EACH CORRECTIVE ACTION SHOUL  CROSS-REFERENCED TO THE APPRO  DEFICIENCY)	D BE COMPLETION
(F 600)	C. The facility support the underlying cause the appropriate treatmedical and for behaves as psychopharmacold utilized to meet the nate of polyamar as psychopharmacold used to enhance the and will never be used discipline or convenie Procedures followed Invisional and diagnost angle stage stage symptoms. 4. interdisciplinary team of the procedures followed uning routine visits the Procedures Followed health included: Item facility in establishing use, dosage and mor medications. Item nur develop behavior man procedures Followed 1. Monitors	Is the goal of determining of behavioral symptoms so nent of environmental, vioral interventions, as well glocal medications can be seeds of individual resident, sigical medications will be quality of life for the resident of or the purpose of noce.  by the Primary Care and sassistantly, or NP otest. 2. Documents is of the use and identifies Evaluates with the effects, and side effects of ions within 14 days of or decreasing dose and hereafter. by the Psychiatrist / mental 1 indicated assist the appropriate guidelines for indicated Help happens of the proper side guidelines for indicated Help happens of the proper side guidelines for indicated Help happens of the proper side guidelines for indicated Help happens of the proper side guidelines for indicated Help happens of the proper side guidelines for indicated Help happens of the proper side guidelines for indicated Help happens of the proper side guidelines for indicated Help happens of the proper side guidelines of the proper si	{F 600	and	and

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		MEDICAID SERVICES					0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE	E CONSTRUCTION	(X3) DATE	SURVEY LETED
HOND PLUN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	NG_		COMP	TELED
						R	-C
		105910	B. WING			11/	02/2021
NAME OF PE	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
					9869 SW 152ND STREET		
CORAL RI	EF SUBACUTE CARE O	ENTER LLC					
	MIAMI, FL 33157						
(X4) ID		ATEMENT OF DEFICIENCIES	ID.		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE
TAG	REGULATURT OR I	SC IDENTIFTING INFORMATION	TAG		DEFICIENCY)	GE.	57.11.0
					22.134.1017		
{F 600}	Continued From page	5	{F €	(00			
	will be performed on a	any resident on			Date of Compliance		
		arterly basis changes and					
	will be reported to the						
		vioral care plans that include					
		armacological interventions.					
		rdinates the interdisciplinary					
	team resident reviews						
	medications.	OI , . ,					
	medications.						
	D	Calculate and all and a second					
		ident # 1's sheet					
	revealed, he was adn						
		diagnoses included but were					
	not limited to,	and ,					
	(blockage in the	, tract),					
	and ,						
		Medication Administration					
	and Treatment Recor	d for Resident #1 revealed,					
	medication included:						
	1 mg (m	illigram) tablet ordered 1					
	tablet to be given by	at bedtime for					
	diagnosis of						
		let ordered 1 tablet to be					
	given by every						
	diagnosis of						
		n tablet, ordered 2 tablets to					
		ice a day for diagnoses of					
	oo givoir oy tiv	ioc a day for diagnoses of					
	Record review of the	Comprehensive Minimum					
		nterview with the MDS					
		n at 9:48					
		nt #1 was Re-admitted to the					
	facility on						
	comprehensive MDS,						
	a score of 15 on the .						

( ), which indicated that the resident was able to verbalize his needs and was not

		ID HUMAN SERVICES					M APPROVED
		MEDICAID SERVICES					D. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD	TIPLE CONSTRUCTION NG		COM	E SURVEY PLETED
		105910	B. WING				R-C /02/2021
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS	S. CITY, STATE, ZIP CODE		
				9869 SW 152ND S	TREET		
CORAL R	EEF SUBACUTE CARE O	SENTER LLC		MIAMI, FL 3315	17		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACI	ROVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULI HREFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
{F 600}	revealed that Resider pattern and was able as make self-underst included and include the diagnosis. Review of the care pirevealed a care plan #1 exhibited behavior. Resident #1 will be at response to situations Approaches included Observe for and behavior, of changes as needed plans showed that Resident #1 will be at response to situations and was a pattern. Approaches included response to the pattern of the properties of the pattern of	Further review of the MDS at #f had a clear speech to understand others as well cool. His active diagnoses	{F €	100}			

records showed no records to indicate that he was monitored for his diagnosis of . . , . . . . or

		ID HUMAN SERVICES MEDICAID SERVICES					APPROVED 0. 0938-0391
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY
		105910	B. WING				-C 02/2021
NAME OF P	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE		
CORAL R	EEF SUBACUTE CARE O	CENTER LLC			669 SW 152ND STREET IAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
(F 600)	for the use of the mg tablet. Further review of Beh showed the resident if occumented as "Afrai of (Initiated had a total of 9 epison of nine different epison hours of 7:00 AM to 7 20, and 25. Four diff Afraid/Panic occurred AM, on , and the prison of the prison occurred facility's only interven of his routine medicat tablet by at being the prison of the prison occurred the prison occurred the prison occurred the prison occurred facility's only interven of his routine medicat tablet by at being the prison occurred facility's only intervent of the prison occurred the prison of the prison occurred the prison oc	avior Monitoring Sheets and multiple episodes di/Panic': During the Month on ) Resident #1 des of Araid/Paniar. Five out des occurred between the .00 PM. on .17, erent episodes of between 7:00 PM to 7:00 PM. on .27 and 28. Interventions for Routine'; Indicating that the itom was the administration ion; .1 mg titime. For Diagnosis of .10 pm. on .10 pm	⟨F €	600}			

episodes of afraid/panic exhibited by Resident #1.

### PRINTED: 11/30/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES STA

ENTERS FOR MEDICARE & MEDICAID SERVICES O							
TEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED				
	105010	R MING	R-C				

9869 SW 152ND STREET

105910 11/02/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

CORAL REEF SUBACUTE CARE CENTER LLC MIAMI, FL 33157 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (F 600) Continued From page 8 (F 600) Review of behavior monitoring sheets for .... for Resident #1 showed the resident continued to be monitored for episodes of Afraid / Panic, Resident #1 had a total of 17 different episodes during the month of ..... Four out 17 different episodes of Afraid/Panic occurred between 7:00 AM to 7:00 PM: on ..., ... ,3,4,and 5. The intervention noted Routine QHS (every night at bedtime) indicating that the facility's only intervention was the administration of his routine medication: , 1 mg tablet 1 tablet by at bedtime. Further review of . . . . . . 's behavior monitoring record showed that Resident #1 had 13 out of 17 different episodes of Afraid/Panic during the evening shift (7:00 PM to 7:00 AM) that 20, 21, 24, 26,27 and 28. The intervention noted "Refer to Nurses Notes." Review of the Nurses Progress Notes for showed no record that addressed any of the episodes of afraid/panic exhibited by Resident #1. Review of the behavior monitoring sheet for ....., showed that Resident#1 had a total of three episodes of Afraid/Panic, Two episodes of Afraid/Panic occurred during the day shift (7:00 AM to 7:00 PM) on and on the day of his .. Resident #1 also had one episode of Afraid/Panic between interventions for each episode noted "Routine

QHS." indicating that the facility's only intervention was the administration of his routine 

AND

Facility ID: 111356

FORM APPROVED

		ID HUMAN SERVICES				APPROVED
CENTERS FOR MEDICA	\RL&I					0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		PLE CONSTRUCTION	LETED
		105910	B. WING	_		-C 02/2021
NAME OF PROVIDER OR SUPPL	JER			Г	STREET ADDRESS, CITY, STATE, ZIP CODE	
					9869 SW 152ND STREET	
CORAL REEF SUBACUTE	CARE C	ENTER LLC			MIAMI, FL 33157	
PREFIX (EACH DE	FICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
(F 600) Continued From bedtime.	m page	9	{F €	300	0}	
	ord tha	ss notes for it addressed the afraid/panic Resident #1.				
with documented by assigned CNA observed runn my med pass a immediately as as I grabbed it another staff in to his room. The aspale was transferre board was plate [1] and the staff of the	th time y LPN, (Certificial Certificial Ce	rses progress notes dated noted as 11:00 PM Staff C revealed: "Resident ed Nursing Assistant] was into me while I was doing erbalized code blue, I la staff member to call 911 inflitator machine. I assigned to get the crash cart. I ran fents skin color was noted no, was noted resident wheelchair to the bed, Jersel has made and the staff of the staff o				

Review of the investigative report and interview 

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES			FORM	M APPROVED	
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391		
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		105910	B. WING			-C 02/2021	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
CORAL RI	EEF SUBACUTE CARE (	CENTER LLC		9869 SW 152ND STREET MIAMI, FL 33157			
(X4) ID PREFIX TAG	(EACH DEFICIENC	RY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION DIENCY MUST BE PRECEDED BY PULL PREFIX Y OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE	
{F 600}	nurse reviewed the fa she investigated the observations of the vi Nurse reported that s recording on "Tuesda The investigative rep at 2:54 PN Nursing Assistant (Cf residents' room [room B), Registered Nurse	of 10  M revealed, the regional cility's video recording as event. She documented her deo. The Clinical Regional he reviewed the video by or Thursday last week." ort noted that on Saturday Resident #1's Certified 4A) (Staff A) went into the #1 at 4:18 PM. Nurse (Staff (RN)was passing meds, so in and out of foroms." At	{F 60	0)			

backboard placed, and .

4:30 PM the friend (Resident #4) leaves Resident #1's room. The video showed that at 4:52 PM meal was delivered to Resident #1's room. His Door remained open the whole time. At 5:21 PM the Nurse (Staff B) went into Resident #1's room. At 5:43 PM the CNA [Staff A] picked up the tray. Noted that he ate 100%, At 6:25 PM it appears the door is shut from inside the room. No one checked on the resident or attempted to enter the room from approximately 6:25 PM to 8:15 PM (Staff C, LPN) was scheduled to start her shift at 7:00 PM, no indication that she checked on Resident #1 until the CNA called her at around 8:15 PM. At 8:15 PM the CNA tried to get into the room and noted that the door was closed. The CNA tried to open the door, but it was blocked. (Staff A) was in the room for a few second, leaves the area gets the nurse and the crash cart... The Regional nurse explained that the CNA had to push the door open and when he entered, he noted Resident #1 seated in his wheelchair. unresponsive with a bag over his

stated that he pulled the bag off Resident #1 and ran to get help. A code was called as well as 911, staff responded to this resident's room where they transferred him to the bed, a

Facility ID: 111356

. The CNA

initiated. Law

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

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		D HOWAIN SERVICES			FORM APPROVED
CENTER	S FOR MEDICARE & I	MEDICAID SERVICES			OMB NO. 0938-0391
	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	NSTRUCTION	(X3) DATE SURVEY COMPLETED
		105910	B. WING		R-C 11/02/2021
NAME OF P	ROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP CODE	
			9869	SW 152ND STREET	
CORAL R	EEF SUBACUTE CARE O	CENTER LLC	MIA	MI, FL 33157	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
{F 600}	enforcement and EM' thereafter and pronou Residents body was t Examiner's office.	T responded shortly inced this Resident. The ransferred to the Medical	{F 600}		
	Certified Nursing Assi- worked in the facility floated on different un- care of Resident #10 CNA surplained that R the Bed B at the wind was empty. Staff A, C #1 was alert and liked with the door closed, go to the bathroom an isolation precautions, schedule for that wee he worked AM -3:00 PM and fror continued on Saturda from 7:30 AM to 11:31 the day of the inciden from my break which when I came an noticed that the door one of the CNAs. He door, I thought he might with something. When noticed the resident with something. When noticed the resident plastic bag over his locked. He normally f one on each side of in misde of it. Once I op inside of it. Once I op Insid	at 3:53 PM with Staff A, stant (CNA) revealed, he for about one year and tits every week. He took n Friday, ( ) and ), when he . Staff A, Oka sassigned to ow and Bed A by the door NA reported that Resident 1 to stay in his room alone He required assistance to dremained in his room on Staff A, CNA reveled his kend was on Friday, d a double shift from 7:00 n 3:00 PM to 11:30 PM. He y Los again work 1 PM. Staff A explained, "on I came is from 8:00 PM to 1:30 PM. He y Los again work 1 PM. Staff A explained," on I store to commended: I pushed the ght have blocked the door 1 reas stifting in his chair with a sad two trash containers, is bed, with plastic bag ened the door, I notice the 1 took the plastic bag ened the door, I notice the 1 took the plastic bag ened the door, I notice the			

nurse was on the hallway. We went to get the

		ID HUMAN SERVICES MEDICAID SERVICES					M APPROVED D. 0938-0391	
FATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		PLE CONSTRUCTION  G	(X3) DATE COMP	SURVEY PLETED	
		105910	B. WING	_			/02/2021	
NAME OF P	ROVIDER OR SUPPLIER		•	Γ	STREET ADDRESS, CITY, STATE, ZIP CODE			
CORAL R	EEF SUBACUTE CARE O	CENTER LLC			9869 SW 152ND STREET MIAMI, FL 33157			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHOULD	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCECE TO THE APPROPRIATE DEFICIENCY)		
{F 600}	crash cart, she called transferred the resided intilated the . The ambulance arrived. The interviewed me. I could after the detective intexplained that sometime aggressive and had be such as he refused a shave and Staff A cor allowed Staff A to sha that long ago, maybe would sometimes get one time, he took off toold the nurse on the asked her to come to translate. I explained here to take care of h	code blue. The nurse and I nt from the wheelchair, they all continued until the peolice arrived they all continued until the he police arrived they until any ender the facility until arviewed me." Staff A, CNA mes Resident #1 was ehaviors like refusing care haircut and refused to winced Resident #1 and ve him. Staff A added "not two weeks". [Resident #1] angry and yell at staff; "like his gown and threw at me, I floor about the behavior and the room and help me to [Resident #1] that I was im, and that there was no e toward me, [Resident #1]	{F €	301	0}			
	with the Director of N. Clinical Regional Nun nurses on the floor us monitoring sheets. The monitor and documer would report each bel Behaviors that are repehaviors that are un behavior that are un behavior that might p such as, The of , depen about anybody, the ci include provide emoti activities, it is whateve	se, the DON explained; The usually complete the behavior te nurses are the ones that it the behaviors, the CNA havior to the nurses. ported and documented are usual for the patient and any ut the patient in distress, plan of care for diagnoses do not necessary to a plan of care for diagnoses do not necessary to non a support for all staff. For onal support for all staff. For						

feelings. Encourage socialization. Provide

DEPART	MENT OF HEALTH AN	D HUMAN SERVICES				FORM	APPROVED	
CENTER	S FOR MEDICARE & I	MEDICAID SERVICES					0. 0938-0391	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION		SURVEY LETED -C	
		105910	B. WING				02/2021	
NAME OF P	ROVIDER OR SUPPLIER			Г	STREET ADDRESS, CITY, STATE, ZIP CODE			
			9869 SW 152ND STREET					
CORALR	EEF SUBACUTE CARE C	ENTERLLC			MIAMI, FL 33157			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E ATE	(X5) COMPLETION DATE	
(F 600)	feedback to reinforce MD (Medical Doctor) Psych consult as nee as or record review of Resis showed, Resident #1 included: 1.  at bedtime for 50 mg tab was asked about Resither the bedtime for 50 mg tab was asked about Resithat showed no plan addressed his use of diagnosis of or the Clinical Regional care plan on record significant for a resis would normally uses awith a resident that he Another to riside effects, which management. The us monitor for depending on the resist hat are verbally able exhalization, we also We document behavit the specific behavior skill nurses' notes. We we would monitor for include steepiness, faccoordination, and continued record	positive behaviors. Notify of changes as needed.  ded and Administer  dered. During the interview,  dealth #1's clinical record  of care that specifically  or his  Both the DON and  Nurse agreed there was no  pecific to the use of the  medication and  dent on we  ame type of interventions as  as a diagnosis of  his period of interventions as  as a diagnosis of  his part of medication  e of requires we  we would do is monitor  is part of medication  e of requires we  we would to be nonitor  is part of medication  of the basic of  requires we  we would to be nonitor  is part of medication  of requires we  we monitor  dent. We have residents  to report, we look for  look at signs or symptoms.  ros on the behavior sheet,  that occurs and on the daily  ren it comes to the  side effects which could  tigue, abnormal  "During the interview  review of Resident #1's  Nexplained." We have	(F é	600	);			

, it shows that we monitor for behaviors "Fear/Panic, . . . , kind of stuff." According to

		ID HUMAN SERVICES MEDICAID SERVICES					APPROVED 0. 0938-0391	
FATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
NO PLAN OF	CURRECTION	IDENTIFICATION NUMBER:	A. BUILD	NG				
		405040	B. WING				-C	
		105910	D. VVIIVG	_		11/	02/2021	
NAME OF PE	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
CORAL RI	EF SUBACUTE CARE O	ENTER LLC	9869 SW 152ND STREET					
			MIAMI, FL 33157					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD IS CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
{F 600}	the nurse's document	ation on the Behavior	{F (	600	0}			
		esident #1 had panic/ explained: "The nurses and that the resident was						
	the . He did to	ver his health. He did not like alk about it sometimes. He						
	intervention was the r	and 2nd. The only nedication as documented						
		toring Sheets We do not itoring record for the use of						
	Regional Nurse both							
	Resident #1's behavio	ors and acknowledged there notes that addressed any						
	of the resident's beha							
		Nurse Manager agreed						
	such documentation v	vas necessary.						
		05 PM, during an interview ined that Resident #1 gave						
		was depressed, and that the						
		ally very good at letting us						
		ny indication, not only						
		history, or any indication of hey usually call me for an						
		t of the patients that are						
	taking .	, they usually generate a						
	consult for me. If the	patient had shown any signs						
	or symptoms, indicati							
		, the staff would						
		e Psychiatrist acknowledged						
		#1 once, on and						
	that his diagnoses inc							
	Psychiatrist on	at 10:56 AM revealed.						
	Psychiatrist on							

above-mentioned Behavior Monitoring Sheets found in Resident #1's clinical record. The

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DEPART	VIENT OF HEALTH AN	ID HUMAN SERVICES					APPROVED	
CENTER	S FOR MEDICARE & I	MEDICAID SERVICES				OMB NO. 0938-0391		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	SURVEY	
NO POR OF	OURICETION	IDENTIFICACION NOMBER.	A. BUILDI	iNG				
		105910	B. WING				-C	
NAME OF PE	ROVIDER OR SUPPLIER	100010	1	F	STREET ADDRESS, CITY, STATE, ZIP CODE	1 139	02/2021	
NOWAL OF T	OVIDER OR SUFFEIER			1	9869 SW 152ND STREET			
CORAL RE	EEF SUBACUTE CARE O	CENTER LLC		1	MIAMI, FL 33157			
(X4) ID	SUMMARY ST/	ATEMENT OF DEFICIENCIES	ID.	_	PROVIDER'S PLAN OF CORRECTION		(305)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)				COMPLETION DATE		
			+		DEFICIENC!)			
{F 600}	Continued From page	a 15	{F €	รดด				
,,		d that he met with facility	1 "	,,,,	1			
		esident's behaviors and if						
		needed. The Psychiatrist						
	was asked about Res	sident #1's behaviors. The						
		he was not aware that						
		behaviors. Upon discussion						
		ed episodes of afraid/panic						
	noted on Resident #1	he was not aware of any of						
		aviors and stated that the						
		unicate said behaviors to						
		stated that the facility staff						
	should have commun	icated any ,						
	afraid/panic episodes							
		t #1 to him. "If they tell me I						
		omething. The nurses						
		did not tell me about those					ļ	
		n, I would have definitely lid have gone to see him,					1	
	maybe change the me							
	maybe change the m	edication.						
	On at 2:5	1 PM, review of Social						
	Services assessment	dated and						
		ility's Social Services Staff;						
	Social Services Direct							
		SA), Staff F, it was revealed						
		responsible for assessing						
		dmission, quarterly, and evealed social services saw						
		round the facility, assess for						
		of Mental Status) score,						
		s. The SSD stated he went						
		to complete the initial						
	assessment on	. Review of the social						
	services note dated .							
		able to Resident #1 and						
		eeded The						
	and assessmer	nt indicated the resident had					(	

little interest or pleasure in doing things,

		D HUMAN SERVICES					APPROVED
		MEDICAID SERVICES					0. 0938-0391
	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		LE CONSTRUCTION	OMB NO (X3) DATE (X3) DATE (X4) DATE (X5) DATE (X6) DATE (X7) STATE, ZIP CODE  EET  DERS PLAN OF CORRECTION PRINCECTIVE ACTION SHOULD BE	LETED
		105910	B. WING			1	-C 02/2021
NAME OF P	ROVIDER OR SUPPLIER			Г	STREET ADDRESS, CITY, STATE, ZIP CODE		
		ENTER LLO			9869 SW 152ND STREET		
CURAL K	EEF SUBACUTE CARE O	ENTERELC			MIAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 600}	frequency, 2 to 6 day or hopeless, frequency or hopeless, frequency or having little energy Poor appetite or over days. The Social Sen followed the question Health Questionnaire interest / pleasure in depressed, or hopele asleep or sleeping for energy, feeling bad at #1's] assessment sho was a six which had a symptom of fee he had poor appetite, and was feeling down news. The SSD report of the state of the half of the state of the half of the hal	s. Feeling down depressed y, 2 to 6 days. Feeling lired , frequency 7 to 11 days. eating, frequency 7 to 11 days. eating, frequency 7 to 11 days. eating, frequency 7 to 11 dives Director explained they naire on the form Patient (PHO-9) which asks about doing things, feeling down, ss. trouble falling /staying or much, if tired, feeling little bout yourself. (Resident tweed the score result for his in indicated that the resident liting tired having low energy, little interests in doing stuff . He was upset about the ted he did not address hat he was feeling down, seident had diagnoses of at his medications. He was . I saw that he was . I saw that he was . He was a patient that we en, very social, attended mything, I asked the depressed, he said it was ras not much I could do aware of, "The tor reported they usually its concerning behaviors ngs and never knew that he hen asked why there was	₹F (	5600	))		

, at 10:01 AM with

Staff B Registered Nurse (RN) reported working

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					FORM	APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				C	OMB NO	. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		DNSTRUCTION		(X3) DATE COMP	LETED
		105910	B. WING				R- 11/4	02/2021
NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE			
				9869	SW 152ND STREET			
CORAL R	EEF SUBACUTE CARE O	CENTER LLC		MIA	MI, FL 33157			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE		(X5) COMPLETION DATE
(F 600)	in the facility since worked with (Residen from 7:00 AM to 7:00 and oriented times th needs well. He norms AM/10:00 AM. He like On the day of the incl isolation precautions. He like On the day of the incl isolation precautions. He like On the day of the incl isolation precaution of the control of the	this year and normally the thing of the common of the comm	₹F €	600}				

received the treatment and that it was effective. I did not document on the nurses notes that the

	ID HUMAN SERVICES					APPROVED
CENTERS FOR MEDICARE &		_				0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		CONSTRUCTION	1	LETED
	105910	B. WING				-C 02/2021
NAME OF PROVIDER OR SUPPLIER			- 5	TREET ADDRESS, CITY, STATE, ZIP CODE		
			1	869 SW 152ND STREET		
CORAL REEF SUBACUTE CARE				MAMI, FL 33157		,
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
desperate, he allower treatment. Sometime usually ask a lot abort episode ofn. nexpected. The purpor Monitoring Sheet is tonedication, a related to the behavior taking the medication Refer to nurses' note the records agreed it anything about the re. Staff B stated hast: 'can have at least thraw to the state of the state of the state of the records agreed it anything about the re. Staff B stated hast: 'can have at least thraw to the state of the state	an episode of on, I did not see him to be on the did not see was no record to explain sident's or behavior. It's established that a patient se small episodes of have a big one. Big ones on the nurses notes. The for monitoring sheet is to seems effective throughout behavior monitoring sheet seems effective throughout behavior monitoring sheet is to seems effective throughout behavior monitoring sheet in did not not reflect the exact nature, vior, she did not know, could see, "I also documented no 10th, 11th, 16th, 17th, all noticed the behavior, I me. I did not think that I ate it to the Psychiatrist. We or diagnoses of hen explained that with a	₹₽ €	600)			

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

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		ID HOMAIN SERVICES				RM APPROVED		
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB N	O. 0938-0391		
STATEMENT OF DEFICIENCIES IND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		105910	B. WING		I	R-C 1/02/2021		
NAME OF P	ROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP CODE	=			
CORAL R	EEF SUBACUTE CARE (	CENTER LLC	1	SW 152ND STREET VII, FL 33157				
(X4) ID PREFIX TAG	(EACH DEFICIENC		ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
{F 600}	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		{F 600}					

or ..... while under her care, Staff C again

DDINTED: 11/30/2021

CENTERS FOR MEDICARE & MEDICAID SERVICES   CANDIDATE			D HUMAN SERVICES					M APPROVED	
IDENTIFICATION NUMBER:  105910  B. WIND  STREET ADDRESS. CITY, STATE, ZIP CODE 11702/2021  STREET ADDRESS. CITY, STATE, ZIP CODE 1888 SW 192ND STREET MAMI, FL 33157  SREET MACH PROVIDER OR SUPPLIER  CORAL REEF SUBACUTE CARE CENTER LLC  SIMMAY STATEMENT OF DEFICIENCIES (RACH DEFICIENCY AUGIT BE PRECEDED BY FULL RECOLLATION OR LISC IDENTIFYING INFORMATION)  FREFIX TAG  CONTINUED From page 20 reported, "no", when asked about her handwritten nurses" notes dated 12:00PM Staff C, stated: "do yeah, one time, I had to call the police because he was complaining of so much , Staff C was asked to clarify if she had called the police. Staff C stated: "the yeal dical the police. Staff C stated: "the dical the police." Staff C LPN explained; the police was called to help Resident #1 calm down while she helped him transfer to the hospital.  The facility's removal plan included: Residents who have a diagnosis of , and were audited to ensure they have an effective plan of care in conjunction with implementing policies and procedures to identify risk factors and change in and behavior as well as side effects and effectiveness of these medications  The Administrator/ Director of Nursing (DON) educated facility staff on a one-to-one basis including Licensed Nursing Staff, and Social Services regarding behavioral health with emphasis on monitoring residents prescribed	CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	D. 0938-0391	
NAME OF PROVIDER OR SUPPLIER  CORAL REEF SUBACUTE CARE CENTER LLC    DAI ID   SUMMARY STATEMENT OF DEFICIENCIES   REACH DEFICIENCY MUST BE PRECEDED BY PLLL   RECULATION OF DEFICIENCY MUST BE PROVIDED BY PRECEDED BY PROVIDED BY									
INMED PROVIDER OR SUPPLIER  CORAL REEF SUBACUTE CARE CENTER LLC  SIMMANY STATEMENT OF DEPOSITIONS PRIEFIX GEACH GERICARV MILET AR PRECEDED BY PILL REGULATORY OR LISCIDENTEYING INFORMATION)  (F 600)  Continued From page 20 reported, "no", when asked about her handwritten nurses" notes dated to clarify if she had called the police or if Resident #1 had called the police, staff C stated that Resident #1 was the one who called the police. Staff C Stated: "He did call the police)" Staff C LePn explained; the police was called to help Resident #1 cand come while she helped him transfer to the hospital.  The facility's removal plan included: Resident #2 cand mown while she helped him transfer to the hospital.  The facility's removal plan included: Resident #3 cand mown while she helped him transfer to the hospital.  The facility's removal plan included: Resident #4 cand mown while she helped him transfer to the hospital.  The facility's removal plan included: Resident #4 cand mown while she helped him transfer to the hospital.  The facility's removal plan included: Residents who have a diagnosis of, and, were audited to ensure they have an effective plan of care in conjunction with implementing policies and procedures to identify risk factors and changes in, and, medications and identifying possible risk factors and changes in and behavior as well as side effects.  Administrator/ Divector of Nursing (DON) educated facility staff on a one-to-one basis regarding, nelect.  The Corporate nurse consultant will in-service administrative staff on a one-to-one basis regarding and Neglect.  The Corporate nurse consultant will in-service administrative staff on a one-to-one basis regarding, nelect. informed care				A. BUILU	ING	'	١,		
NAME OF PROVIDER OR SUPPLIER  CORAL REEF SUBACUTE CARE CENTER LLC    MAMM, FL 33157   MAMM,			105910	B. WING					
CORAL REEF SUBACUTE CARE CENTER LLC    DAY ID   PREFIX   SUMMARY STATEMENT OF DEFICIENCIES   PREFIX   RECOLLATORY OR LISC IDENTIFYING INFORMATION    PREFIX   TAG   PROVIDER'S PLAN OF CORRECTION   CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE   COMPLETE A CROSS-REFERENCE TO THE APPROPRIATE   CROSS-REFERENCE TO	NAME OF P	ROVIDER OR SUPPLIER	111111		Г	STREET ADDRESS CITY STATE ZIP CODE	1 11	10212021	
MAMI, FL 33157   MAMINEST PRECEDED BY FULL PREPARED (ACH DETRICENCY AUGIT BE PRECEDED BY FULL PREPARED (ACH DETRICENCY ACTION SHOULD BE CARDS REPERENCED TO THE APPROPRIANTE DETRICENCY ACTION SHOULD BE CARDS REPERENCED TO THE APPROPRIANTE DETRICENCY ACTION SHOULD BE CARDS REPERENCED TO THE APPROPRIANTE DETRICENCY ACTION SHOULD BE CARDS REPERENCED TO THE APPROPRIANTE DETRICENCY AUGIT BE DETRICED TO THE APPROPRIANTE DETRICED TO THE APPROPRI									
FREENX TAG  RECOLLATORY OR LISC IDENTIFYING INFORMATION)  (F 600)  Continued From page 20  reported, "no", when asked about her handwritten nurses" notes dated 12:00PM Staff C, stated: "do yeah, one time, I had to call the police because he was complaining of so much, Staff C was asked to clarify if she had called the police, staff C stated that Resident #1 was the one who called the police. Staff C stated: "the did call the police, staff C stated that Resident #1 was the one who called the police. Staff C stated: "the did call the police." Staff C LPN explained; the police was called to help Resident #1 cam down while she helped him transfer to the hospital.  The facility's removal plan included: Resident #1 cam down while she helped him transfer to the hospital.  The facility's removal plan included: Resident #1 cam down while she helped him transfer to the hospital.  The facility's removal plan included: Resident #1 cam down while she helped him transfer to the hospital.  The facility's removal plan included: Residents who have a diagnosis of, and, were audited to ensure they have an effective plan of care in conjunction with implementing policies and procedures to identify risk factors and changes in and behavior as well as side effects and effectiveness of these medications  The Administrator/ Director of Nursing (DON) educated facility staff on a one-to-one basis including Licensed Nursing Staff, and Social Services regarding behavioral health with emphasis on monitoring residents prescribed	CORAL R	EEF SUBACUTE CARE O	ENTER LLC			MIAMI, FL 33157			
reported, "no", when asked about her handwritten nurses" notes dated 12:00PM Staff C, stated: "oh yeah, one time, I had to call the police because he was complaining of so much , Staff C was asked to clarify if she had called the police or if Resident ## had called the police, staff C stated that Resident ## was the one who called the police. Staff C stated: "he did call the police" Staff C LPN explained; the police was called to help Resident ## calm down while she helped him transfer to the hospital.  The facility's removal plan included: Residents who have a diagnosis of were audited to ensure they have an effective plan of care in conjunction with implementing opticies and procedures to identify risk factors and change in and behavior as well as side effects and effectiveness of these medications  The Administrator/ Director of Nursing (DON) educated facility staff on a one-to-one basis including Licensed Nursing Staff, and Social Services regarding behavioral health with emphasis on monitoring residents prescribed and medications and identifying possible risk factors and changes in and behavior as well as side effects and and medications and identifying possible risk factors and changes in and behavior as well as side effects.  Administrator/DON in serviced all staff on a one-to-one basis regarding , neglect. informed care	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	COMPLETION	
and benavioral health.  Social services and nursing staff were educated		Continued From page reported, "no", when a handwritten nurses' in 12:00PM Staff C, sit had to call the police complaining of so mu to clarify if she had ce complaining of so mu to clarify if she had ce with the complaining of so mu to clarify if she had ce with the complaining of so mu to clarify if she had ce with the complaining of so mu to clarify if she had ce with the clarify of the complaining of she were audients who have a were audients who have a were audients had care implementing policies in she factorized in the complaining	asked about her ottes dated:  asked about her ottes dated to dated:  oth, Staff C was asked alled the police or if Resident ce, staff C stated that one who called the police.  d call the police! Staff C olice was called to help on while she helped him all.  plan included: a diagnosis of, and ted to ensure they have an in conjunction with and procedures to identify pe in and behavior as dieflictiveness of these rector of Nursing (DON) on a one-to-one basis ursing Staff, and Social heavioral health with gresidents prescribed medications and sk factors and changes in serviced all staff on a arding and Neglect consultant will in-service a one-to-one basis serviced all staff on a rading and Neglect consultant will in-service a one-to-one basis lect informed care			DEFICIENCY)	or or the		

informed care including a newly added

questionnaire regarding ......

		ID HUMAN SERVICES MEDICAID SERVICES					M APPROVED 0. 0938-0391
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION	(X3) DATE COMP	
		105910	B. WING			111	02/2021
NAME OF P	ROVIDER OR SUPPLIER	•		Г	STREET ADDRESS, CITY, STATE, ZIP CODE		
CODAL D	EEF SUBACUTE CARE O	CENTED I C			9869 SW 152ND STREET		
CORAL K	EEF SUBACUTE CARE C	CENTER ELC			MIAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 600}	Newly hired staff will in orientation by the Dresidents with diagnoresidents with diagnoresidents with a diagreement of the staff or the staff of the staff or the next the quart Services/designed wis creening on all active.	be educated during N/designee on monitoring sis of and initor for behaviors related to and any noted side and	(F c	6000			
	who are prescribed .	plan indicated: Residents, and vere audited to ensure a					
		avalance to effectively					

monitor for effectiveness and side effects of the

Facility ID: 111356

DDINTED: 11/30/2021

		ID HUMAN SERVICES				FOR	M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0. 0938-0391
	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		105910	B. WING			1	t-C
		100010		_		1 11)	02/2021
NAME OF P	ROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE		
CORAL R	EEF SUBACUTE CARE O	CENTER LLC		1	9869 SW 152ND STREET		
				丄	MIAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPT DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 600}	Continued From page	22	{F 6	snn	11		
(, 000)			1, 1	500	"		
		escribed , medication re a care plan is developed					
	to effectively manage						
		N educated facility staff on					
		cluding Licensed Nurses,					
	Certified Nursing Aide						
		n regarding residents who					
	are prescribed	, and ,					
	medications to effecti	vely monitor for the					
		nedication and side effects.					
		IDS) Corporate consultant					
		one In service with MDS					
		an In service with nursing					
		pping and implementing a					
	plan of care.	NI advected facility staff on					
		N educated facility staff on cluding Licensed Nursing					
		g Aides on developing and					
		n for Residents who have					
		ively manage the Residents					
		Corporate consultant will					
		Inservice with MDS staff					
	and will conduct an Ir	service with nursing staff					
	regarding developing care.	and implementing a plan of					
	Newly hired staff will I	he educated by the					
		orientation on residents					
	who are prescribed						
		medications to effectively					
		veness of the medication					
	and side effects.						
	An audit of all active r	residents who are on					
	p 4						
		sure a care plan has been					
		ely monitor for effectiveness					
	and side effects of the						
	Monitoring for Correc	tive Action:					

The DON or designee will audit 100% of all active

		ID HUMAN SERVICES					M APPROVED
		MEDICAID SERVICES		_			0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		PLE CONSTRUCTION		PLETED
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NAME OF PE	ROVIDER OR SUPPLIER			Ē	STREET ADDRESS, CITY, STATE, ZIP CODE		UZIZUZI
Work or	WIDER OF OUT I CE.			1	9869 SW 152ND STREET		
CORAL RE	EEF SUBACUTE CARE O	ENTER LLC		L	MIAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	REFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
{F 600}	Continued From page and , . medication have been developed of the medications an Data will be collected twice a week for one next two quarters.  Related to: Accident I bevices a failure to pro and accurately and et identify and treat chabehaviors, the facility Residents who have :	weekly to ensure care plans to monitor the effectiveness of monitor for side effects, weekly for a month then quarter then monthly for the heart of the monitor of the moni	{F 6		DEFICIENCY)		
	residents with a diagr						

are in place and reflect the behaviors of the resident and that referrals for mental health are

Facility ID: 111356

		ID HUMAN SERVICES MEDICAID SERVICES					RM APPROVED NO. 0938-0391
TATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		105910	B. WING				1/02/2021
	ROVIDER OR SUPPLIER	CENTER LLC		9	STREET ADDRESS, CITY, STATE, ZIP CODE 1869 SW 152ND STREET WIAMI, FL 33157		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETION DATE
{F 600}	conducted as warrand or designee will audit diagnosis of	led from the audit. The DON 100% of residents with a and to ensure heets accurately reflect Data will be collected weekly e a week for one quarter reset two quarters. Social II conduct the n all active residents.  plan was verified during an and telephone on revealed sampled sis of or addication were being rivices and no concerns well-being of the residents servations.  90 AM, the Nursing Home stated that she provided one training session to all erer fully trained and raining was provided to all lude the monitoring and illustion with residents defor, he correct information on the sheets.  ion/In-Services logs until, Monitoring, ress Notes and behavior Monitoring residents	(F-C	600}			

		ID HUMAN SERVICES MEDICAID SERVICES					M APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		LE CONSTRUCTION	(X3) DATE COMP	
		105910	B. WING	_		11/	02/2021
NAME OF PE	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
		THE TENTED I I O			9869 SW 152ND STREET		
CORAL RI	EEF SUBACUTE CARE O	ENTERELC			MIAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 600}	medications effectives Informed Care, behavior, and side eff factors and changes is to identify side effects medication. Camonitor for effectivemedifects. —Docume and following care pile in order to effect symptoms. Able to ideffectively manage the effectively manage the feet of the effectively manage the manage of the effectively manage the effectively manage the effectively manage that one to one (1:1)E myrovided Administrator, Assist Review of the in-service of the Social Services Oepa Planning staff. On provided to 8 staff me staff) and (1 staff) and (	rects. Able to identify risk n and behavior. Able to identify risk n and behavior. Able to identify risk n and behavior. Able to identify of and so identify a	₹F €	6000			
	Review of the audit lo	gs revealed weekly audits					

for residents who are on

lents who are on ..., and ... medication and side effects

DDINTED: 11/30/2021

		ID HUMAN SERVICES				FORM	APPROVED
		MEDICAID SERVICES					0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL* A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		105910	B. WING				-C 02/2021
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				98	69 SW 152ND STREET		
CORAL R	EEF SUBACUTE CARE O	ENTER LLC		M	IAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 600}	Continued From page of the medication.	26	{F 6	(00			
	Neglect and 1-800-96- was The facility's Behavior and Monitoring last reviewed with no con-	eef Subacute Resident Policy revised on al Assessment, Intervention					
{F 641} SS=D	§483.20(g) Accuracy The assessment mus resident's status. This REQUIREMENT by:	of Assessments. t accurately reflect the is not met as evidenced ew and interview, the facility	{F €	i41}	F641 Resident #1 no longer resides in the		
	assessments were ac resident (Resident #1 residents during a cor The Findings included Record review of Res Minimum Data Set (M revealed; the assess #1 returned to the fac "acute hospital." His Status ( ) score the resident was speech, ability to und	curately coded for one ) out of ten sampled mplaint investigation.  d:  ident #1's Comprehensive IDS) MDS dated ment showed that Resident filtry on from Brief Interview of Mental was 15 out of 15, meaning He had Clear erstand and be understood and no behaviors. The			The MDS Consultant educated the MD staff on accurate coding All Residents have the potential to be affected Current Resident's recent MDS was reviewed for accurate coding of the resident's active diagnosis. Any inaccurate coding identified will be modified. The MDS Consultant educated the MD staff on accurate coding of active diagnosis. Policy: Certifying Accuracy of the		

from the hospital. He was . . . . of

Resident Assessment was reviewed

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/30/2021

		D TIOMET CERTIFICE			FURW APPRU	
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0	J391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		105910	B. WING		R-C 11/02/2021	
NAME OF PE	ROVIDER OR SUPPLIER		1 :	STREET ADDRESS, CITY, STATE, ZIP CODE		
			1 ,	9869 SW 152ND STREET		
CORAL RI	EEF SUBACUTE CARE O			MIAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLET	TION
{F 641}	He had a plast month and also horior to admission. Senoted he used Section If Combined Sec	whor to admission within the ad a two to six months ctoton N for Medications , and or Active Diagnoses coded; and diastolic	(F 641)	The MDS Consultant educated the M staff on accurately coding the resider active diagnosis The Interdisciplinary Team will review MDS coding for accuracy during the resident's care plan review The MDS Nurse/designee will condu audit of residents MDS coding for active diagnosis with each submission for 3 months to ensure the Resident's MD coded accurately for active diagnosis. The MDS Nurse/designee will report results of the audits to the Quality Assurance and Performance Improvement Committee for review a feedback Responsible Party: DoN/designee Date of Compliance:	nt's  the  ct an  tive  S is  the	•
	§483.21(b) Comprehe	ensive Care Plans				

		ID HUMAN SERVICES MEDICAID SERVICES					M APPROVED 0. 0938-0391
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		PLE CONSTRUCTION 3	(X3) DATE COMP	
		105910	B. WING	_		11/	02/2021
NAME OF P	ROVIDER OR SUPPLIER			Γ	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
		THE LLO			9869 SW 152ND STREET		
CORAL R	EEF SUBACUTE CARE O	GENTER LLC			MIAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	§483.21(b)(1) The fac implement a compret care plan for each res resident rights set for 8483.10(c)(3), that in objectives and timefir medical, nursing, and needs that are identificated assessment. The codescribe the following (i) The services that or maintain the reside physical, mental, and required under §483.3(ii) Any services that under §483.24, §483. provided due to the re under §483.10, inclue treatment under §483.(iii) Any specialized si rehabilitative services provide as a result of recommendations. If findings of the PASAF rationale in the resided () In consultation with resident's portional services the community was assessive services provided and the resident's portional services that the resident's portional services are serviced outcomes.	cility must develop and bensive person-centered sident, consistent with the that \$483.10(c)(2) and cludes measurable ames to meet a resident's mental and ,	F	65			
		n the comprehensive care in accordance with the					

requirements set forth in paragraph (c) of this

		ID HUMAN SERVICES				RM APPROVED	
		MEDICAID SERVICES	1			OMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES IND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION  3	CON	E SURVEY MPLETED	
		105910	B. WING		- 1	R-C 1/02/2021	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
			- 1	9869 SW 152ND STREET			
CORAL R	EEF SUBACUTE CARE (	CENTER LLC		MIAMI, FL 33157			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 656	by: Based on interviewe reviewed, the facility an effective care plan treatments required t 10 sampled residents complaint investigatic develop a care plan to and did not deve addressed the Reside medications facility also failed to care plan for diagnos by falling to e related to Resident # report episcoles of Aff As a result of these d' 11 suffocated himself bag over his event of the facility of the health and safe to the facility. On the facility to the health and safe to the facility. On the facility and the facility of the provided for the facility of the facilit	is not met as evidenced , policy and records lailed to implement, develop for the quality of care and y one (Resident #1) out of reviewed during this n. The facility failed to a address Resident #1's lop a care plan that nft's use of , , , and , The mplement the Resident's as of , , and fectively monitor behaviors Is diagnoses and failed to aid/Panic to the psychiatrist, deficient practices, Resident by placing a plastic trash sulting in his by , it was determined the posed immediate jeopardy ty of all residents admitted clitty's immediate Jeopardy ty of all residents admitted clitty's immediate Jeopardy riffed by the survey team as and interviews. It was lty completed in-services for related to the Immediate	F 61		cated and residents to to veness on staff menting a staff are potential venes of the control of		
	of the facility's correct The immediate jeopa removed on	tive actions implemented.  It was determined to be try for F656 were lowered to		for behaviors related to their diag			

a (D) for No actual harm with a potential for more

than minimal harm that is not immediate jeopardy

medication were audited to ensure a care

plan is developed to manage their ...

		ID HUMAN SERVICES MEDICAID SERVICES				FORM APPROVED DMB NO. 0938-0391
TATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED
		105910	B. WING			R-C 11/02/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
				9869 SW 152ND STREET		
CORAL R	EEF SUBACUTE CARE O	ENTER LLC		MIAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIAT	
F 656	person-centered care measurable objective resident's physical, needs is developed a resident.  The Policy Interpretat noted: 1. The interdisk with the resident and representative develocomprehensive, perseach resident. 2. The derived from a thorout information gathered comprehensive assess.  Review of the care planeached, a care plane	Facility's policies and titled; Care e Person - Centered atement, A comprehensive, plan that includes s and functional nd implemented for each ion and Implementation ciplinary team in conjunction his/her family or legal ps and implements a on -centered care plan for care plan interventions are gh analysis of the as part of the ssment.  ans for Resident #1 dated id behaviors of list: Resident #1 will be able response to situations by procaches included,, observe for changes, and behavior, notify MD	F 62		eness and side to cool, Care son-Centered of each care and monitor the cts of the MDS staff mplementing of the cts of the MDS staff mplementing of the cts of the MDS staff mplementing of the cts of the MDS staff mplementing the cts of the MDS staff mplementing ucated by the tatation on edd, and the cts of the cts of the mplementing the cts of the cts	d, nts a nd no
	was at risk for alterati Approaches included				that are	

, encourage verbalization of feelings, administer . . . . . . . as ordered. There

clinical meeting to ensure a

		D HUMAN SERVICES					M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0. 0938-0391
	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		PLETED
		105910	B. WING				-C 02/2021
NAME OF P	ROVIDER OR SUPPLIER		1	s	TREET ADDRESS, CITY, STATE, ZIP CODE	1 11)	OZ,ZOZ I
				9	869 SW 152ND STREET		
CORAL R	EEF SUBACUTE CARE O	ENTER LLC		N	MAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 656	were no care plans in records for the use of of , diagnosis of , milligrar is used to treat mode related to 's' Review of Resident # sheets for the months and , in was monitored for the use of There was no record that Resident #1 was behavior such as danger to self. Furth monitoring sheets rewnultiple episodes do:  During the Month of Jerical Plantic. Five the published of Afraid/Panic. Five the planting sheets rewnultiple episodes do:  Ouring the Month of Afraid/Panic. Five the planting sheets rewnultiple episodes of Afraid/Panic. Five the planting sheets rewnultiple episodes of Afraid/Panic. Five the planting sheets rewnultiple episodes of Afraid/Panic. Five the planting sheets and the planting sheets of the fanity of the fundating that the fact the administration of the nurses progres , (From that addresser of that addresser e.g. exhibited by Fundation that the sheet is the planting that the fact that addresser of the nurses progres , whibited by Fundation that the fact that addresser e.g. exhibited by Fundation that the fact that addresser exhibited by Fundation that the fact that addresser exhibited by Fundation that the fact that addresser exhibited by Fundation that the fact t	Resident #1's clinical diagnoses diagnoses and for the use of ins (mg) tablet (	F	656	comprehensive plan of care will be developed and the medications will be monitored for effectiveness and side effects The DON/designee will audit current residents who are on, and medication well and the standard of the side o	kły x s	

blank) for ...., ..., and during the day

		D HUMAN SERVICES MEDICAID SERVICES					M APPROVED O. 0938-0391
TATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		105910	B. WING	_		11.	/02/2021
	ROVIDER OR SUPPLIER SEF SUBACUTE CARE O	ENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 9869 SW 152ND STREET MIAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	monitored during that Laboratored during that Shavior Mc #1, showed that he his Afraid/Panic during the 7:00 AM) that occurre 15, 16, 17, 18, 19, 22 Review of nurses pro (From or record that address afraid/panic exhibited For the Month of) Residen sheet showed the res different episodes during the form of the for	PM) of	F	656	5		

The Behavior Monitoring Sheet dated

DEPARTM	MENT OF HEALTH AN	ID HUMAN SERVICES				FORM	MAPPROVED
CENTERS	FOR MEDICARE & I	MEDICAID SERVICES				OMB NO	0. 0938-0391
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		PLE CONSTRUCTION	1	SURVEY PLETED
		105910	B. WING	_			02/2021
NAME OF PR	OVIDER OR SUPPLIER		_	Г	STREET ADDRESS, CITY, STATE, ZIP CODE		
	EF SUBACUTE CARE O				9869 SW 152ND STREET		
CORAL RE	ENTERLLC			MIAMI, FL 33157			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI- DEFICIENCY)		(X5) COMPLETION DATE
F 656	three episodes. Two cocurred during the d PM) on a of his). He alts: Afraid/Panic between Afraid/Panic between the construction of the constru	esident#1 had a total of pipsodes of Afraid/Panic applied so of Afraid/Panic ay shift (7:00 AM to 7:00 AM shift on the pipsode of 7:00 PM to 7:00 AM shift on terventions for each episode indicating that the facility's the administration of his for a facility of the administration of his for the pipsode of	F	656	6		

Resident # 1's physician orders included the

		D HUMAN SERVICES					APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES					0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION	l	LETED
		105910	B. WING				-C 02/2021
NAME OF PE	ROVIDER OR SUPPLIER		-	Г	STREET ADDRESS, CITY, STATE, ZIP CODE		
					9869 SW 152ND STREET		
CORAL RE	EEF SUBACUTE CARE O	ENTER LLC			MIAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	É VTE	(X5) COMPLETION DATE
F 656	diagnosis of for diagnosis of every day. The DON Nurse were apprised record showed no pla addressed his use of diagnoses of, and and the Clinical Region ocare plan on record showed no pla addressed his use of explained; "For a resi would normally use the interventions as with diagnosis of do is monitor for side medication managem requires we monitor for side medication managem requires we monitor for eyendristion, we symptoms. We docube show of the second of the second of the plant of the use of for behavior sheet and dispectific behavior that sill nurses for notes. We for the use of for behaviors "Fearurs behavior monitoring so the plant of the use of for behaviors "Fearurs behavior monitoring is panic", episode panic", episode panic / epi	at bedtime for at bedtime for and	F	65			
		ral staff reported that the frustration over his health.					

He did not like the . He did talk about it sometimes. He had . . . , on . . . . and

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DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPL(ER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		PLE CONSTRUCTION	1	PLETED
		105910	B. WING			1	-C 02/2021
NAME OF P	ROVIDER OR SUPPLIER		•	Π	STREET ADDRESS, CITY, STATE, ZIP CODE		
					9869 SW 152ND STREET		
CORAL R	EEF SUBACUTE CARE O	ENTER LLC			MIAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	2nd. The only interved documented on the July and the Use of Clinical Regional Nurresidents record for a Resident #1's behavis attack written notes it resident's behaviors cand the Clinical Nurse documentation was n Interview on Psychiatrist explained indication that he was staff was "usually very when there is any ind also past history, or a They usu evaluation I see me taking onsult for me . If the signs or symptoms, ir or have notified me." Th	ntion was the medication as ehavior monitoring sheets ehavior monitoring record and an artificial section of the property of t	F	65			
	Psychiatrist on the Psychiatrist did no above-mentioned bet found in Resident #1' explained that he mel discussed the resider adjustments are need Psychiatrist reported	sluded and d Interview with the at 10:56 AM revealed of review the havior monitoring sheets					

of multiple documented episodes of afraid/panic noted on Resident #1's clinical record, The

		ID HUMAN SERVICES MEDICAID SERVICES					MAPPROVED 0. 0938-0391
TATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION	(X3) DATE COMP	
		105910	B. WING	_		11/	02/2021
NAME OF F	ROVIDER OR SUPPLIER			Г	STREET ADDRESS, CITY, STATE, ZIP CODE		
CORAL R	EEF SUBACUTE CARE O	CENTER LLC		1	9869 SW 152ND STREET MIAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	Psychiatrist reported the above-mentioned not communicate sair Psychiatrist explained have communicated episodes and other be Residentiff. "If they it something. The nurse not tell me about thos would have definitely have gone to see him medication"  On Registered Nurse(RNN worked with Resident 7:00 PM. Worked with Resident 7:00 PM. Another tell resident of the resident of th	he was not aware of any of behaviors. The nurses did to behaviors to him. The stream of the that the facility staff should any arraid/panic ehavior exhibited by ell me I would definitely do so usually call me. They did se episodes. Had I known, I done something, would a, maybe change the ell of the consumer of	F	654	6		

What I documented was that he had one behavior of . . . . . . . . . Staff B, RN explained that

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DEPARTMENT OF HEALTH A						FORM.	APPROVED
CENTERS FOR MEDICARE	& MEDICAID SERVICES					OMB NO.	0938-0391
STATEMENT OF DEFICIENCIES IND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRU	JETION		(X3) DATE S COMPLI	ETED
	105910	B. WING				R-0 11/0:	2/2021
NAME OF PROVIDER OR SUPPLIER			STREET ADD	DRESS, CITY, STATE, ZIP COD	DE		
	OFWEED 11 O		9869 SW 15	52ND STREET			
CORAL REEF SUBACUTE CAR	CENTER LLC		MIAMI, FL	. 33157			
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC (DENTIFYING INFORMATION)	ID PREF TAG	ix c	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIA		(X5) COMPLETION DATE
the episode reason for the treat and why he remain that her documente monitoring sheets is was related to the Resident #1 received was effective. Staff in the nurses notes episode of not see him to be diadminister his truthe purpose of the to follow for a press and document the behavior, for which medication. The first nurses notes. Staff to explain anything behavior. Staff 8 spatient can have at patient can have at given the patient of the purpose of the to see if the medication. The nurses notes. Staff to explain anything behavior. Staff 8 spatient can have at given the to see if the medication that the conservation of the control of the con	eking about the ment. The intervention, during was teaching about the ment, what was the reason, et in isolation. Staff B stated tion on the behavior booth the afraid/panic episode treatment, that at the treatment and that it B stated: "I did not document that the resident was having because! I did my action, I did esperate, he allowed me to esperate, he allowed me to estament." Staff B reported that behavior monitoring sheet is riched , medication, pisodes related to the resident is taking the ervention was to refer to B agreed there was no record about the resident's attaining the envention was to refer to B agreed there was no record about the resident's action if they have a big one. Big urment on the nurses' notes. Behavior monitoring sheet is tion seems effective thwhat the behavior is seen the medication is	F	656				

10th, 11th, 16th, 17th, 24th, 25th, 26th. When I noticed the behavior, I did not report

		ID HUMAN SERVICES					M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES					0. 0938-0391
	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	1	PLETED
		105910	B. WING	_			t-C (02/2021
NAME OF P	ROVIDER OR SUPPLIER			Γ	STREET ADDRESS, CITY, STATE, ZIP CODE		
CODAL D	EEF SUBACUTE CARE O	CENTED I C			9869 SW 152ND STREET		
CORAL K	EEF SUBACUTE CARE C	CENTER ELC			MIAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	to anyone. I did not the communicate it to the monitor him for any of that she would have a re variety in a person cause them to have a seemed well, he did not reject care, or cor discussion of Resider reported: "I am surprofwhen remained in his bed. approximately 7:10 P asked we close the di and interview with That at approx in a paper a paper and provided that the second provided the second provided that the second provided that the second provided that the second provided the se	ink that I needed to psychiatrist. We did not psychiatrist. We did not like the control of the c	F	65	6		
	resident in his room a Record review of phy #1 showed a Telepho for a managem of Resident #1's clinic documentation to indi received said	at approximately 5:21 PM). sician's orders for Resident ne Order dated nt consult. Further review all record showed no cate that Resident #1 nsult. from the hospital on nosis of 10 mg, for five days Review of Resident #1's ad no care plans on file that fits diagnosis of					

Residents who have a diagnosis of

who have a diagnosis of \_\_\_, and were audited to ensure they have an

DEPARTI	MENT OF HEALTH AN	D HUMAN SERVICES				FORM	APPROVED
CENTER	S FOR MEDICARE & I	MEDICAID SERVICES				OMB NO	0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION		LETED
		105910	B. WING				-C 02/2021
NAME OF PR	ROVIDER OR SUPPLIER			Г	STREET ADDRESS, CITY, STATE, ZIP CODE		
CORAL REEF SUBACUTE CARE CENTER LLC					9869 SW 152ND STREET		
CURAL RI	EF SUBACUTE CARE C	ENTERLLC			MIAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	risk factors and chang well as side effects ar medications. The Administrator/ Discussion of the decided facility staff including Licensed N. Services regarding be emphasis on monitoring and identifying possible ris and behavior at Administrator/DON in one-to-one basis regard. The Corporate nurse administrative staff or regarding neg and behavioral health Social services and no no an one-to-one basis informed care questionnaire regarding. Newly hired staff will brieflastic staff will be decided to staff	In conjunction with and procedures to identify per in and behavior as id effectiveness of these rector of Nursing (DON) on a one-to-one basis ursing Staff, and Social rhavioral health with ng residents prescribed , medications and sk factors and changes in swell as side effects. serviced all staff on a rurding and Neglect. consultant will in-service a one-to-one basis leed informed care uursing staff were educated by Administrator/DON on including a newly added by and	F	651			
		and procedures to identify  ge in and behavior as					

well as side effects and effectiveness of these medication and to ensure behavior monitoring

		ID HUMAN SERVICES MEDICAID SERVICES					M APPROVED 0. 0938-0391
TATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI		LE CONSTRUCTION	(X3) DATE COMP	
		105910	B. WING			110	02/2021
NAME OF PR	OVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
					9869 SW 152ND STREET		
CURAL RE	EF SUBACUTE CARE C	SENTER LLC			MIAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	the resident and that: The DON/designee w residents with a diagr weekly to reflect the resident's the behaviors have interv with the behavior and monitored. Data will b month then monthly fo for the next two quark Services/designee wil soreening on all active Regarding the facility implement a compreh The facility's removal who are prescribed medicatio care plan has been de monitor for effectiven medication care plan has been de monitor for effectiven medication care plan has been de monitor for effectiven medication care plan has been de monitor for effectiven medication care plan has been de monitor for effectiven medication care plan has been de monitor for effectiven medication care plan has been de monitor for effectiven medication care plan has been de monitor for effectiven medication care plan has been de monitor for effectiven medication care plan has been de monitor for effectiven medication care plan has been de monitor for effectiven medication care plan has been de monitor for effectiven medication care plan has been de monitor for effectiven medication care plan has been de monitor for effectiven medication care plan has been de monitor for effectiven medication care plan has been de monitor for effectiven medication care plan has been de monitor for effectiven medication care plan has been de monitor for effectiven medication care plan has been de monitor for effectiven medication care plan has been de monitor for effectiven medication care plan has been de monitor for effectiven medication care plan has been de monitor for effectiven medication care plan has been de monitor for effectiven medication care plan has been de monitor for effectiven medication care plan has been de monitor for effectiven medication care plan has been de monitor for effectiven medication care plan has been de monitor for effectiven medication care plan has been de monitor for effectiven medication care plan has been de monitor for effectiven medication care plan has been de monitor for effectiven medication car	nd reflect the behaviors of side effects are monitored. Ill audit 100% of all active losis of and ensure behavior sheets behaviors, that those entitions placed to intervene any side effects of medications are ecollected weekly for a or one quarter then monthly ers. Social Iconduct informed e residents.  Is failure to develop and ensure a personal plan indicated. Residents and weekly for a service and the service are plan: plan indicated. Residents and side effects of the escribed, medication re a care plan is developed to effectively uses and side effects of the escribed, medication re a care plan is developed the, in declaring Licensad Nurses, as on developing and in regarding residents who and	F	655	6		

The Administrator/DON educated facility staff on

		ID HUMAN SERVICES MEDICAID SERVICES					MAPPROVED 0. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPL(ER/CLIA	(X2) MUL	TIP	LE CONSTRUCTION	(X3) DATE	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	iNG		COMP	PLETED
						R	-C
		105910	B. WING	_		11/	02/2021
NAME OF PE	ROVIDER OR SUPPLIER			Г	STREET ADDRESS, CITY, STATE, ZIP CODE		
CODAL DI	EF SUBACUTE CARE O	SENTED LLC			9869 SW 152ND STREET		
CORAL RI	EF SUBACUTE CARE C	ENTER LLC			MIAMI, FL 33157		
(X4) ID		ATEMENT OF DEFICIENCIES	1D	_	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE
IAG	REGULATURE UNI	SO DEITH ING INFORMATION	IAG		DEFICIENCY)	AIL	
					-		
F 656	Continued From page	41	F	65	6		
	, ,	cluding Licensed Nursing	,		*		
		g Aides on developing and					
		n for Residents who have					
		ively manage the Residents					
		Corporate consultant will					
		Inservice with MDS staff					
	and will conduct an In	service with nursing staff					
		and implementing a plan of					
	care.						
	Newly hired staff will I						
	who are prescribed	orientation on residents					
		nedications to effectively					
		veness of the medication					
	and side effects.	torious of the modification					
	An audit of all active it	esidents who are on					
		, and , . medication					
		sure a care plan has been					
		ely monitor for effectiveness					
	and side effects of the						
	Monitoring for Correc						
		will audit 100% of all active					
		veekly to ensure care plans					
		to monitor the effectiveness					
		d monitor for side effects.					
		weekly for a month then					
	twice a week for one	quarter then monthly for the					
	next two quarters.						
	Related to: Accident I						
		vide adequate supervision					
	and accurately and el						
	identify and treat char-	nges in and s removal plan indicated:					
	Residents who have a						
		ted to ensure behavior					

sheets are in place to identify behaviors, interventions placed to intervene with the

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				O. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		E SURVEY PLETED
		105910	B. WING		<b>I</b>	R-C /02/2021
	ROVIDER OR SUPPLIER	CENTER LLC	98	REET ADDRESS, CITY, STATE, ZIP COE 69 SW 152ND STREET IAMI, FL 33157	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(X5) COMPLETION DATE
F 656	and mental health ev. The Administrator/DC a one-to-one basis in Certified Nursing Aide regarding behavioral monitoring residents of diagnosis and to enst mental health evaluat Social services and no a one-to-one basis informed car questionnaire regard! Newly hired staff with orientation on behavi monitoring residents orientation on behavi monitoring residents orientation and behavi monitoring residents or the social service and to enst mental health evaluat the facility has condu- residents with a diagr to ensure are in place and refle- resident and that refe- conducted as warrant or designee will audit diagnosis of , behavior monitoring residents of behavior monitorings resident's behaviors. for a month then twic then monthly for the r Services/designee wi informed screening o	Is made for , , , , , and Is made for , , , , and , and Is all actions , Is advantage and , and	F 656			

		ID HUMAN SERVICES					M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	O. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPL(ER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	COM	E SURVEY PLETED
		105910	B. WING				R-C /02/2021
NAME OF P	ROVIDER OR SUPPLIER			8	TREET ADDRESS, CITY, STATE, ZIP CODE		
				g	869 SW 152ND STREET		
CORAL R	EEF SUBACUTE CARE (	SENTER LLC		٨	MAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	and receiving _ m provided care and se about the safety and were noted during ob Con _ at 10: Administrator (NIA); education and one to staff to ensure staff and to provide the thing of any sassessed and identificant to provide the behavior monitoring s Review of the Educat provided dated topics included: Documentation. Prog Sheets. Monitor for for and prescribed medications effective informed Care, which is the staff of the sta	edication were being vices and no concerns well-being of the residents servations.  00 AM, the Nursing Home stated that she provided one training session to all ere fully trained and raining was provided to all lude the monitoring and itude the monitoring recorned information on the heets.  ion/In-Services logs until Monitoring Monitoring Monitoring residents and and and services. Understand  feets, Able to identify risk in and behavior. Able is of and and and services and serv	F	656			

..... provided by Corporate to the

		ID HUWAN SERVICES					RM APPROVED			
CENTER	S FOR MEDICARE &	MEDICAID SERVICES					O. 0938-0391			
	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		NSTRUCTION	CON	E SURVEY MPLETED			
		105910	B. WING			- 1	R-C 1/02/2021			
NAME OF P	ROVIDER OR SUPPLIER		_	STRE	EET ADDRESS, CITY, STATE, ZIP CODE		.,			
				9869	SW 152ND STREET					
CORAL R	EEF SUBACUTE CARE (	CENTER LLC		MIA	MI, FL 33157	R'S PLAN OF CORRECTION D				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(XS) COMPLETION DATE			
F 656	Administrator, Assist Review of the in-serv revealed 75 nursing staff. On training was provided of the Social Services Depa Planning staff. On provided to 8 staff ms staff) and (1 strinservice was provided to 8 staff ms staff) and (1 strinservice was provided to 8 staff ms staff) and (1 strinservice was provided for residents who are and of the medication.  Record review of the Procedures for Care Person-Centered was The Resident Policy 1-800-96.  The facil Intervention and Monowas revie facility's policy for was revied.  On at 06: Coordinator revealed training from DON and Nurse. The training whe was encoding pressuring that if the personsuring that if the personsure that it the personsure that if the personsure that it is the	ant, Director of Nursing. to logs dated to lossessible losse	F	656						

side effects and monitoring the effectiveness of the medication. Staff D stated that if she read

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					0: 11/30/2021 MAPPROVED
CENTER	S FOR MEDICARE & I	MEDICAID SERVICES					0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE	
		105910	B. WING				-C 02/2021
ALLAND OF DE	ROVIDER OR SUPPLIER	100010	1		TREET ADDRESS, GITY, STATE, ZIP CODE	1 119	32/2021
NAME OF PE	(OVIDER OR SUPPLIER		- 1		869 SW 152ND STREET		
CORAL RE	EEF SUBACUTE CARE O	ENTER LLC			NAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI- DEFICIENCY)		(X5) COMPLETION DATE
F 656	to resident or family it to resident or family it the assessment look and the , med behaviors are noticed to ensure that every and make sure the be medication administra medication and the C behaviors is done by care and any staff in tany signs for symptor , and immediately to admin Review of the audit to for residents who are just of the medication.	that triggers or when talking o communicate with direct or the patient). Also, during to see if resident has any also when patient receiving iteation to ensure the 1 both on the care plan and patient has behavior sheet haviors sheets match the ation records for the are Plan. Monitoring the the nurses providing direct the building that observed ns pertaining to , and for them to report it istration or supervisor.  gas revealed weekly audits on medication and side effects	Ff	656			
	Person-Centered was The Resident Policy 1-800-96- The facili Intervention and Mon was revie facility's policy for was revie	Plans, Comprehensive s revised on Neglect and was revised on ty's Behavioral Assessment, itoring last revised informed Care revised					
(F 684) SS≃D	Quality of Care CFR(s): 483.25		{F 6	84}			

§ 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

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TAREAUT CONTINUED A DESCRIPTION OF PROVIDER OR SUMPLY COMPLETED TAG  WAS DEPARTMENT OF DEPICIENCES TAG  PREFEX TAG  PROVIDERS PLAN OF CONSECTION TAG  PREFEX TAG  PROVIDERS	DEFAILI	WENT OF HEALTHAN	ID HOMMIN SERVICES			FOR	M APPROVED
IDENTIFICATION NUMBER:  105910  B. WING  TREET ADDRESS. CITY, STATE, ZIP CODE  9898 9W 152ND STREET  MIAMI, FL 33157  SUMMANY STATEMENT OF DEFIDIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL RECOULATION OF U.S.C. IDENTIFYING INFORMATION)  (F 684)  Continued From page 46 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-entered care plan, and the residents' choices.  This REQUIREMENT is not met as evidenced by: Based on interviews, and records reviewed, the facility failed to ensure, identify, and provide needed care and services such as the care planning, monitoring assessment and consistent response to manage diagnoses of, experienced by one (Resident #1) out of 10 sampled residents reviewed during a complaint survey. The facility failed to effectively monitor behaviors related to Resident #1 suffocated himself by placing a trash bag over his resulting in by  The findings included:  Record review of physician's orders for Resident #1 subrocated for , management consult. Further review of Resident #1's clinical record showed no documentation that Resident #1 received said , consult.  Record review of the nurse's notes dated  Record review of the nurse's notes dated	CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB N	O. 0938-0391
I 105910  INAME OF PROVIDER OR SUPPLIER  CORAL REEF SUBACUTE CARE CENTER LLC  SUBMANAY PROFESSOR OF DESCRIPTIONS  PROPORTING SUPPLIER  SUBMANAY PROFESSOR OF DESCRIPTIONS  RECOLLATORY OR LISC IDENTIFYING INFORMATION)  (F 684)  Continued From page 46 facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents evolve teatment and care in accordance with professional standards of practice, the comprehensive person-entered care plan, and the residentist choices. This REQUIREMENT is not met as evidenced by:  Based on interviews, and records reviewed, the facility failed to ensure, identify, and provide needed care and services such as the care planning, monitoring assessment and consistent response to manage diagnoses of , experienced by one (Resident #1) out of 10 sampled residents reviewed during a complaint survey. The facility failed to effectively monitor behaviors related to Resident #1 stignoses of and and , While unsupervised in his room, Resident #1 suffocated himself by placing a trash bag over his resulting in by				1			
CORAL REEF SUBACUTE CARE CENTER LLC    SUMMARY STATEMENT OF DEFICIENCIES   SUMMARY STATEMENT OF DEFICIENCIES   CRACH DEFICIENCY NUTS BE PRECEDED BY PULL TAG			105910	B. WING			
MIAMI, FL 33157   SUMMANY STATEMENT OF DEFICIENCIES   CACH DEFICIENCY MUST BE PRECEDED BY FULL RECOLLATION ON U.S.C IDENTIFYING INFORMATION)   PREPRIX TAG   PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CHOOSE-AREFERENCE TO THE APPROPRIATE	NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SUMMARY STATEMENT OF DEFICIENCES   DID   PREVIOUS RESPICATION SHOULD BE   CROSS-REFERENCED TO THE APPROPRIATE   CROSS-REFERENCED OF THE APPROPRI				- 1	9869 SW 152ND STREET		
FREENX TAG  REQULATORY OR LSC IDENTIFYING INFORMATION)  FRESH TAG  Continued From page 46 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 interviews, and records reviewed, the facility failed to ensure, identify, and provide needed care and services such as the care planning, monitoring assessment and consistent response to manage diagnoses of experienced by one (Resident #1) out of 10 sampled residents reviewed during a complaint survey. The facility failed to effectively monitor behaviors related to Resident #1's diagnoses of and and, while unsupervised in his room, Resident #1 suffocated himself by placing a trash bag over his resulting in by  The findings included:  Record review of physician's orders for Resident #1 sclinical record showed no documentation that Resident #1 received said onsuit.  Record review of the nurse's notes dated  #Record review of the nurse's notes dated  #Record review of the nurse's notes dated  #Record review of the nurse's notes dated	CORAL RI	EEF SUBACUTE CARE (	CENTER LLC		MIAMI, FL 33157		
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 interviews, and records reviewed, the facility failed to ensure, identify, and provide needed care and services such as the care planning, monitoring assessment and consistent response to manage diagnoses of, experienced by one (Resident #1) out of 10 sampled residents reviewed during a complaint survey. The facility failed to effectively monitor behaviors related to Resident #1's diagnoses of and and. While unsupervised in his room, Resident #1 suffocated himself by placing a trash bag over his resulting in by  The findings included:  Record review of physician's orders for Resident #1 schwed a telephone order dated for , management consult. Further review of Resident #1's clinical record showed no documentation that Resident #1' received said consult.  Record review of the nurse's notes dated	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	OULD BE	COMPLETION
revealed, Resident #1 was administered two  500 milligram (mg) tablets because of in the penis, continued with, until 4 PM when he (Resident #1) called 911 at 7:00 PM to  when the training training training to the reviewed.	(F 684)	facility residents. Bas assessment of a resis that residents receive accordance with profine practice, the compret care plan, and the resident practice, the compret care plan, and the resident plan in the practice plan, and the resident plan in the practice plan in the plan in asset in the plan in the pla	ed on the comprehensive dent, the facility must ensure treatment and care in essional standards of hensive person-centered sidents' choices. It is not met as evidenced and records reviewed, the e, identify, and provide videntify, and provide videntify, and provide dentify and provide dentify and provide dentify and provide dentify and provide ressessment and consistent diagnoses of providentify and provide during a complaint illied to effectively monitor Resident #19 out of 10 viewed during a complaint illied to effectively monitor Resident #15 diagnoses of and while which willied to effectively monitor and provide and provide the side of the sid	(F 684	F684 Corrective action: Resident #1 no longer resides in facility The Administrator/designee educ Licensed Nurses and Certified Ni. Aides regarding	asted arsing in the with onitoring is so that the second in the second i	

Licensed Nurses and Certified Nursing

		ID HUMAN SERVICES				M APPROVED
		MEDICAID SERVICES	_			O. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION	CON	E SURVEY IPLETED R-C
		105910	B. WING			K-C 1/02/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE	
CORAL R	EEF SUBACUTE CARE (	EENTER LLC		9869 SW 152ND STREET MIAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCES	N OF CORRECTION EACTION SHOULD BE ITO THE APPROPRIATE DENCY)	(X5) COMPLETION DATE
(F 684)	Record review of the showed that Residen Hospital on penal, and "Diagnoses during thi Acut problem, other specific unspecified complication device, encounter"  Record review of phy revealed, the Hospital of the Hospital, he was cassociated complications associated complication and the hospital, he was cassociated complication associated complication. Review of clinical recreturned to the nursin Review of physician of the short of the Record Review Administration Record Review Administration Record Review of the Record review of nursidocumented every de Record review of nursidocumented by Staff Nurse (LPN) dated	Clinical Transition of Care #1 arrived to the to the so visit noted:  of specified. Unspecified e  of specified. Unspecified e  and initial  sician's progress dated Resident #1 transferred to secondary to, ining of from his Upon admission to flagnosed with  with He was anidd He was with ghome on order sevealed Resident #1 g home of the Medication of order sevealed Resident #1 g home of the Medication of order sevealed Resident #1 g home of the Medication of order sevealed Resident #1 g home of the Medication of the Medic	{F 68	Aides regarding	initioning for, as are placed, e educated during assessment, initioning for, are placed experience, will call meeting to annagement, are effective.  e Action:  a dudit Residents ion Record weekly ensure Resident's fective.  I report the results ality Assurance and	

observed banging on his bed and yelling, stating

A BUILDING			ID HUMAN SERVICES					M APPROVED
IDENTIFICATION NUMBER:  105910  8. WIND  STREET ADDRESS. CITY., STATE, ZP CODE  9889 SW 1528/0 STREET  MIAMI, FL 33157  PROVIDER OR SUPPLIER  CORAL REEF SUBACUTE CARE CENTER LLC  SUMMANLY STATEMENT OF DEFICIENCIES  FREEFLY ADDRESS. CITY., STATE, ZP CODE  9889 SW 1528/0 STREET  MIAMI, FL 33157  PROVIDERS PLAN OF CORRECTION  PREPRIX  TAG  FREGULATORY OR LSC IDENTIFYING NEORMANICH)  FREGULATORY OR LSC IDENTIFYING NEORMANICH)  (F 684)  Continued From page 48  that he had severe and requested to be sent to the hospital. ABD (abdomen) assessed noted soft, non-tender, voiced at the touch of lower region. Call placed to MD [Medical Doctor] to send to hospital for evaluation. Call place to 911 emergency. Paramedics arrived, assessed palent, and transferred him to the closest hospital at 11:30 PM.  Resident #1 returned from the hospital on His orders included 10 mg for five days for diagnosis of His orders included noted that Resident #1 returned from the hospital on His orders included noted that Resident #1 reported he had been having some discomfort in his secondary to his Physician progress notes dated noted, "He reports that the he was having on Friday was resolved." (indicating that Resident#1 was in on ).  Record review of the MAR for howed staff documented levels of zero every day of the month.  Continued record review of the MAR and nurses notes for Resident #1 showed no record to indicate the facility acknowledged Resident #1's	CENTER	S FOR MEDICARE &	MEDICAID SERVICES	_			OMB NO	0. 0938-0391
NAME OF PROVIDER OR SUPPLIER  CORAL REEF SUBACUTE CARE CENTER LLC  SIMMAMY STATEMENT OF DEPICIENCES  SUMMAMY STATEMENT OF DEPICIENCES  SUMMAMY STATEMENT OF DEPICIENCES  SUMMAMY STATEMENT OF DEPICIENCES  REGULATORY OR LIST GENTIFYING INFORMATION)  (F 684)  Continued From page 48 that he had severe and requested to be sent to the hospital. A Bod Jabdoment] assessed noted soft, non-tender, voiced _ at the touch of lower region. Call place to 911 emergency. Paramedics arrived, assessed patient, and transferred him to the closest hospital at 11:30 PM.  Record review of assessment again showed zero documented during the month of including  Record review of physicians' progress notes dated noted, "He reports that the he was having on Friday was resolved." (including that Resident #1 reported he had been having some discomfort in his secondary to his Physician progress notes dated noted, "He reports that the he was having on Friday was resolved." (including that Resident #1 was in on ).  Record Review of the MAR for showed staff documented levels of zero every day of the month.  Continued record review of the MAR and nurses notes for Resident #1 showed no record to indicate the facility acknowledged Resident #1's							COMP	PLETED
STREET ADDRESS, CITY, STATE, 2IP CODE 989 SW 132ND STREET MIAMI, FL 3157  MAMM, FL 3157  MEQUATORY OR LSC IDENTIFYING INFORMATION)  (F 684)  Continued From page 48 that he had severe , and requested to be sent to the hospital. ABD [abdomen] assessed noted soft, non-tender, voiced , at the fucuch of lower region. Call placed to MD [Medical Doctor] to send to hospital for evaluation. Call place to 91 temergency. Paramedics arrived, assessed patient, and transferred him to the closest hospital at 11:30 PM.  Resident #1 returned from the hospital or with diagnosis of , His orders included 10 mg for five days for diagnosis of , his orders included 20 mg for five days for diagnosis of , his orders included 10 mg for five days for diagnosis of , his orders included 10 mg for five days for diagnosis of , his orders included 10 mg for five days for diagnosis of , his orders included 10 mg for five days for diagnosis of , his orders included 10 mg for five days for diagnosis of , his orders included 10 mg for five days for diagnosis of , his orders included 10 mg for five days for diagnosis of , his orders included 10 mg for five days for diagnosis of , his orders included 10 mg for five days for diagnosis of , his orders included 10 mg for five days for diagnosis of , his orders included 10 mg for five days for diagnosis of , his orders included 10 mg for five days for diagnosis of , his orders included 10 mg for five days for diagnosis of , his orders included 10 mg for five days for diagnosis of , his orders included 10 mg for five days for diagnosis of , his orders included 10 mg for five days for diagnosis of , his orders included 10 mg for five days for diagnosis of , his orders included 10 mg for five days for diagnosis of , his orders included 10 mg for five days for diagnosis of , his orders included 10 mg for five days for diagnosis of , his orders included 10 m			105910	B. WING				
MIAMI, FL 33157   MIAMI, FL 33157   SUMMARY STATEMENT OF ECFICIENCIES   ID PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY MIST BE PRECEDED BY PULL RESULATORY OR LSC DENTIFYING INFORMATION)   PREPRIX TAG   PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY   PREPRIX TAG    (F 684)   Continued From page 48 that he had severe and requested to be sent to the hospital. ABD (abdomen) assessed noted soft, non-tender, voiced at the touch of lower region. Call place to 911 emergency. Paramedics arrived, assessed palent, and transferred him to the closest hospital at 11:30 PM.  Resident #1 returned from the hospital or His orders included 10 mg for five days for diagnosis of with diagnosis of His orders included noted that Resident #1 reported he had been having some discomfort in his noted that Resident #1 reported he had been having some discomfort in his noted that Resident #1 reported he had been having some discomfort in his noted. "He reports that the noted." (Indicating that Resident#1 was in or ), Record review of the MAR for noted." (Indicating that Resident#1 was in or ), Record review of the MAR for noted. "He reports that the he was having on Friday was resolved." (Indicating that Resident#1 was in or	NAME OF PE	ROVIDER OR SUPPLIER		_		STREET ADDRESS, CITY, STATE, ZIP CODE	1	-
MIAMIL F. 33157  MIAMIL F. 33167  TAG  SUMMARY STATEMENT OF DEFICIENCIES IDEA OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL TAG (PREFIX)  TAG (PREFIX)  TAG (PREFIX)  COntinued From page 48  that he had severe, and requested to be sent to the hospital. ABD (abdomen) assessed noted soft, non-tender, voiced, at the touch of lower region, Call placed to MD [Medical Doctor] to send to hospital for evaluation. Call place to MD [Medical assessed patient, and transferred heim to the closest hospital at 11:30 PM.  Resident #1 returned from the hospital on with diagnosis of His orders including  Record review of physicians' progress notes dated , noted that Resident #1 reported he had been having some discomfort in his secondary to his Physician progress notes dated , noted that Resident #1 reported he had been having some discomfort in his secondary to his Physician progress notes dated , noted that Resident #1 reported was resolved. '(Indicating that Resident#1 was in , on ),  Record Review of the MAR for showed staff documented , levels of zero every day of the month.  Continued record review of the MAR and nurses notes for Resident #1 showed no record to indicate the facility acknowledged Resident #1's	CORAL RI	EEE SURACUTE CARE (	ENTERLIC			9869 SW 152ND STREET		
RECOL DEFICIENCY MUST BE PRECEDED BY PULL TAG   REGULATORY OR LSC IDENTIFYING INFORMATION	OOTHE IN	EL GODAGGTE GARE	CHIERCEO		L	MIAMI, FL 33157		
that he had severe and requested to be sent to the hospital. ABD (abdomen) assessed noted soft, non-tender, voiced at the touch of lower region. Call placed to MD (Medical Doctor) to send to hospital for evaluation. Call place to 911 emergency. Paramedics arrived, assessed palent, and transferred him to the closest hospital at 11:30 PM.  Resident #1 returned from the hospital on His orders included 10 mg for five days for diagnosis of  Record review of assessment again showed zero documented during the month of including  Record review of physicians' progress notes dated noted that Resident freported he had been having some discomfort in his secondary to his Physician progress notes dated noted, "He reports that the he was having on Friday was resolved." (Indicating that Resident#1 was in on ).  Record Review of the MAR for showed staff documented , levels of zero every day of the month.  Continued record review of the MAR and nurses notes for Resident #1 showed no record to indicate the facility acknowledge and the continued record review of the MAR and nurses notes for Resident #1 showed no record to indicate the facility acknowledge Resident #1's	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR	3E	COMPLETION
Interview on at 6:00 PM with	(F 684)	that he had severe to the hospital. ABD (soft, non-tender, voice region. Ca Doctor) to send to he place to 911 emerger assessed patient, and closest hospital at 11:  Resident #1 returned with diagnorders included diagnosis of .  Record review of	and requested to be sent abdomen) assessed noted at at the touch of lower ill placed to MD [Medical spital for evaluation. Call cy. Paramedics arrived, I transferred him to the 30 PM.  from the hospital on pair of the sent	(F·	584			

Resident #4 revealed he was close friends with

		ID HUMAN SERVICES			FORM APPRO	
		MEDICAID SERVICES			OMB NO. 0938-0	0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		105910	B. WING		R-C 11/02/2021	
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
CODAL D	EEF SUBACUTE CARE (	CENTED LLC		9869 SW 152ND STREET		
CORAL K	EEF SUBACUTE CARE	JENIER ELC		MIAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLET	TION
(F 684)	Resident #1. Resider 15 on the ( ), which indicat verbalize his needs a	at #4 had a score of 14 out of ed the resident was able to nd was not riew of the Minimum Data hat Resident #4 had a clear ras able to understand the self-understood. During nt ras able to understand the self-understood of the self-und	{F 68	43		

		ID HUMAN SERVICES MEDICAID SERVICES					APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		LE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED -C
		105910	B. WING	_		11/	02/2021
	ROVIDER OR SUPPLIER EEF SUBACUTE CARE O	CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 9869 SW 152ND STREET MIAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
(F 684)	and scale in the MAR every shift. "Staf Resident #1 had conc "He had could be painful, discomfort" During of Resident #1's reco was discharged from orders for diagnosis c mg, one tablet to be a 6 hours for 5 days to 15 days of 1	Our job is to assess for 16 acknowledged that iftions that could cause , as one of his diagnoses, sensation, the interview, clinical review rick showed that the resident the community hospital with if, and for 10 diministered by every histard date of 10 diministered the medication Staff G stated, "It earns I have to give it to him, with the "Staff G stated," it earns I have to give it to him, with the "Staff G stated," it earns I have to give it to him, with the "Staff G stated," it earns I have to give it to him, with the "Staff G stated," it earns I have to give it to him, with the "Staff G stated," it earns I have to give it to him, with the "Staff G stated," it earns I have to give it to him, with the "Staff G stated and oriented times incided his needs well. Staff that Resident #1 had, rhe did at some point take and for about vas not able to explain why ro (0), for the entire and insisted that we, the last times she sday, 100 staff B stated: "Those	(F. 6	5844	).		

documented that Resident #1 called the police because he was in so much , on ......

DEPARTI	MENT OF HEALTH AN	D HUMAN SERVICES				FORM	APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	. 0938-0391
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION	1	LETED
		105910	B. WING				-C 02/2021
NAME OF PE	ROVIDER OR SUPPLIER			Г	STREET ADDRESS, CITY, STATE, ZIP CODE		
					9869 SW 152ND STREET		
CORAL RI	EF SUBACUTE CARE O	ENTERLLC			MIAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
(F 684)	interview Staff C, LPM message was left. Or Staff C was called ag the phone and require in 15 minutes C C was called, Staff C had any complaints o Staff C responded, in 15 minutes of Staff C responded, in complaints. When a that the resident had disconnected. On up telephone interview of the care, Staff C repoasked about her hand had to call the police complaining of so mu clarify the documer indicated that the resident had to call the police complaining of so mu clarify the documer indicated that the resident of the complaining of so mu clarify the documer indicated that the resident of the complaining of so mu clarify the documer indicated that the resident of the properties of the pro	ne committed	(F)				
{F 689} SS=D	Free of Accident Haza CFR(s): 483.25(d)(1)	ards/Supervision/Devices 2)	{F (	889	}		
	§483.25(d) Accidents The facility must ensu						

§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and

Facility ID: 111356

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				FOR	M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		SURVEY PLETED
		105910	B. WING			l	02/2021
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				98	69 SW 152ND STREET		
CORAL R	EEF SUBACUTE CARE O	ENTER LLC		M	IAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
(F 689)	Continued From page	52	{F 6	89}			
	supervision and assis accidents. This REQUIREMENT by:  Based on records refacility failed to ensur monitoring and super resident (Resident #1 residents of the 17 Rt. medications a received failed to effectively mr. Resident #1's diagnor and multiple episode lead to Resident #1's diagnor and multiple episode lead to Resident #1's findings of the survey to the health and safe to the facility.  On he facility.  On he face Removal Plan was revealed that the facility revealed that the facility revealed that the facility and safe to the facility's correct of the facility of the	vision was provided for one ) out of 10 sampled esidents that received and 47 residents that medications. The facility onlitor behaviors related to see of of panic and afraid which elf-inflicted harm. Resident di nhis room, placed a his and suffocated by it was determined the posed immediate jeopardy thy of all residents admitted billity's immediate jeopardy with of all residents admitted billity's immediate Jeopardy riffed by the survey team is and interviews. It was lity completed in-services for related to the immediate			F689 Resident # 1 no longer resides in the facility Nursing Staff involved with Resident # care were educated to effectively monit behaviors related to diagnosis of	or nd s of to als alth	

evaluations.

referrals are made for mental health

		ID HUMAN SERVICES			FORM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIS	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		105910	B. WING		R-C 11/02/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
			1	9869 SW 152ND STREET	
CORAL R	EEF SUBACUTE CARE (	CENTER LLC		MIAMI, FL 33157	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
{F 689}	Continued From page The Findings Include		{F 68	(9) Social services and nursing staff v	were
	was admitted to the fi Resident #1 was an a resident with physical wheelchair and is abl wheelchair and is abl wathroom on his own would ask for assista found by Certified Nu with a plastic bag ove staff immediately call	at 9:00 PM, Resident #1 acility on		educated by Administrator/design informed care including a added questionnaire regarding.  Newly hired staff will be educated orientation on behavioral health w emphasis on monitoring residents and diagnosis ensure referrals are made for mer health evaluations.  New admissions will be reviewed clinical meeting for Inform assessment and behavioral Monits	newly during iith with and to ttal during ed Care
	911 and the resident Record review of the procedures titled, "Sa Residents." Revised I policy statement: Ou environment as free I possible. Residents' assistance to prevent commitment to safety organization. Facility oriented appr	expired.  facility's policy and fetly and Supervision of n , revealed the facility strives to make the rom accident hazards as safety and supervision and accidents are facility wide at all levels of the pack to safety included:		sheet as indicated per diagnosis c and , and , and , and , and reform behavioral health will be initiated a needed The DON/designee will audit resid with a diagnosis of , and weekly x4 and monthly x3 to ensu behavior monitoring sheets accurreflect resident's behaviors and re are made for , and me health evaluations as needed	of alls to alls to alls to alls to alls to all to a
	and demonstrate con and report accident h avoidable accidents. resident-centered app 1.Our individualized, to safety addresses s for individual resident care team shall analy	proach to safety included: resident centered approach afety and accident hazards s. 2.The interdisciplinary ze information obtained id observations to identify		Social Services/designee will audid admitted residents weekly X4 and X3 to ensure they have been scre for informed care  The DON/designee and Social Services/designee will present the of audits to QAPI committee for re and feedback. Responsible parties: DON/Design Social Services/Designee	I monthly seened o results oview

individual residents. 3. The care team shall target

Date of Compliance

DEPARTMENT OF HEALTH AN DENTERS FOR MEDICARE & I			PRINTED: 11/30/2021 FORM APPROVED OMB NO. 0938-0391
ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED R-C
	105910	B. WING	11/02/2021

						R-C
		105910	B. WING	_		11/02/2021
NAME OF PI	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE	
CODAL D	EF SUBACUTE CARE O	ENTERILO		9869	SW 152ND STREET	
CORAL K	EF SUBACUTE CARE C	ENTERELO		MIA	MI, FL 33157	
(X4) ID	SUMMARY STA	VIEWENT OF DEFICIENCIES	1D		PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD BE	COMPLETIO
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG		CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	UNIE
					DE IGENOT)	
{F 689}	Continued From page	54	{F €	89}		
	interventions to reduc	e individual risks related to				
	hazards in the environ	nment, including adequate				
	supervision and assis	tive devices. Systems				
	approach to safety no	ted: 2. Resident supervision				
	is a core of the system	ns approach to safety.				
	Review of the care pla	ans for Resident #1				
	revealed, care plan da	ated ; "Resident				
	# 1 exhibited behavio	rs of ,/agitation.				
	Goals: Resident #1 w	ill be able to display				
	appropriate response	to situations by next review				
	date." Approaches inc	duded, determine cause of				
	, observe for o	changes in mental status,				
	, and behavior, i	notify MD (Medical Doctor)				
	of changes as needed	d. Further review of the care				
	plans showed that Re	sident #1 had diagnoses of				
	and was a	it risk for alterations in				
	pattern. Approaches i	ncluded, observe for				ł
	changes in, end	courage verbalization of				
	feelings, administer	as ordered.				
	Record review of Res	ident #1's behavior				
	monitoring sheets for					
		dicated that Resident # 1				
	was monitored for the	behaviors afraid/panic.				
	Related to the use of	, 1 milligram				
	(mg) tablet. There wa	s no record to indicate that				
	Resident #1 was mon	itored for any other				
	behavior such as	. changes or danger to				
	self. There was no be	ehavior record to indicate				
	that he was monitored	for his diagnosis of				
	and for the					
	Further review of the	behavior monitoring sheets				
		#1 had multiple episodes				
		d/Panic". The behavior				
	monitoring sheet initia					
	Resident #1 had a tot					
		of nine different episodes				
		ours of 7:00 AM to 7:00 PM				

Facility ID: 111356

		ID HUMAN SERVICES MEDICAID SERVICES					APPROVED 0. 0938-0391
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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		LE CONSTRUCTION	(X3) DATE	SURVEY LETED
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						R	-C
		105910	B. WING	_		11/	02/2021
NAME OF PI	ROVIDER OR SUPPLIER			Г	STREET ADDRESS, CITY, STATE, ZIP CODE		
				1	9869 SW 152ND STREET		
CORAL R	EEF SUBACUTE CARE O	CENTER LLC			MIAMI, FL 33157		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	JD.	_	PROVIDER'S PLAN OF CORRECTION		(305)
PREFIX		Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD E		COMPLETION DATE
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					DEFICIENCY)		
(E 000)	0 5 15						
{F 689}	Continued From page		{F €	889	<del>!</del> }		
		), and 25. Four different					
	episodes of Afraid/Pa	nic occurred between the					
	hours of 7:00 PM to 7	7:00 AM, on,, 27					
	and 28. The documer	nted interventions for each					
	episode noted "Routing	ne."					
	Review of the nurses'	progress notes for .					
	, showed no reci	ord that addressed any of					
		exhibited by Resident #1.					
		,,					
	Review of the behavior	or sheets for					
		ted date of, but the					
		sheet showed no record (left					
		, and during the day					
	shift (7:00 AM to 7:00						
	indicating that Reside						
		of monitored during that time.					
		behavior monitoring records					
		ved that Resident #1 had 15					
		Afraid/Panic during the 7:00					
		The Afraid/Panic behaviors					
		ed on , 9, 10, 11, 13,					
		2, 23, 24, 25 and 29. Review					
		ss notes for,					
	showed no recorded						
		afraid/panic episodes					
	exhibited by Resident	i #1.					
	Pavious of Pacidant #	1's behavior sheets for					
	(initi						
		had a total of 17 different					
		anic during the month of					
		17 different episodes of					
		between 7:00 AM to 7:00					
		3, 4,and 5. The intervention					
		Routine QHS [nightly at					
	bedtime]". Further						
	behavior monitoring r	ecord showed that Resident					

#1 had 13 out of 17 different episodes of Afraid/Panic during the evening shift (7:00 PM to

	MENT OF HEALTH AN S FOR MEDICARE &		FORM APPROVED OMB NO. 0938-0391				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		105910	B. WING			1	R-C 11/02/2021
NAME OF PROVIDER OR SUPPLIER				ST	REET ADDRESS, CITY, STATE, ZIP CODE		
CORAL REEF SUBACUTE CARE CENTER LLC				9869 SW 152ND STREET MIAMI, FL 33157			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTIVE PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPROFIDERCY)		BE	(X5) COMPLETION DATE
(F 689)	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RESULATORY OR LSC IDENTIFYING INFORMATION)		₹F €	89)			

Technicians] pronounced his . . . . No obvious

		D HUMAN SERVICES					APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES	_			OMB NO	0. 0938-0391
	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION	l	LETED
		105910	B. WING				-C 02/2021
NAME OF PE	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
					9869 SW 152ND STREET		
CORAL RI	EEF SUBACUTE CARE O	ENTER LLC			MIAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
(F 689)	assigned to this residuable to enter his ro to push very hard to cresident wheelchair with patient side to the push very hard to cresident wheelchair was noted over his the trash bag to see it Patient was not breat CNA then verbalized he found the patient, police. Police officers Contact! The medica transferred residents' Review of the investigation of the video recording as she investigation of the video retrieval to the patient of the video retrieval to the video retrieval	the time of	{F · 6	889	)		

checked on the resident or attempted to enter the room from approximately 6:25 PM to 8:15 PM

TATEMENT OF DEFICIENCIES  (X1) PROVIDER OR SUPPLIER  109910  NAME OF PROVIDER OR SUPPLIER  CORAL REEF SUBACUTE CARE CENTER LLC  (V4) ID PRETAY  (EACH DEFINATION OF DEFICIENCIES OR FULL REGISTRATION OF DEFICIENCY OR LEG DESTIFITING INFORMATION)  (F 689)  (SLGIF C) LPN was scheduled to start her shift at 7:00 PM, no indication that she checked on Resident #1 from the time her shift stated until the CNA called her at around 8:15 PM, At 8:15 PM, the CAN tried to get into the room and noted that the door was closed. The CNA tried to open the door, but it was blocked. Staff A was in the room for a few second, leaves the area gets the nurse and the crash cart. The Regional nurse explained that the Point his wheelchair, unresponsive with a bag over his The CNA stated that he pulled the bag off Resident #1's and ran to get help. A code was called as well as \$111, staff responded to this resident's room where they transferred him to the bed, a backboard was placed, and initiated. Law enforcement and EMTs responded shortly thereafter and pronounced this Resident. The Residents brown where they transferred to the Medical Examiner's office.  During an interview on at 10:56 AM the Psychiatrist reported he was not aware that Resident #1 had any behaviors. Upon discussion of the multiple documented replaced so of afraid/pain: noted on Resident #1 see and on			D HUMAN SERVICES MEDICAID SERVICES						APPROVED 0.0938-0391
INAME OF PROVIDER OR SUPPLIER  COPAL REEF SUBACUTE CARE CENTER LLC  SUBJUNCY OR SUPPLIER  SUBMANY STATEMENT OF DEFICIENCES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  REGULATORY OR LSC IDENTIFYING INFORMATION)  (F 689)  Continued From page 58  (Staff C) LPN was scheduled to start her shift at 7:00 PM, no indication that she checked on Resident #1 from the time her shift started until the CNA called her at around 8:15 PM. At 8:15  PM, the CNA tried to get into the room and noted that the door was closed. The CNA tried to open the door, but it was blocked. Staff A was in the room for a few second, leaves the area gets the nurse and the crash called. The resident's unresponsive with a bag over his The CNA stated that he pulled the bag off Resident #1's and ran to get help. A code was called as well as 911, staff responded to this resident's room where they transferred him to the bed, a backboard was placed, and initiated. Law enforcement and EMTs responded shortly thereafter and pronounced this Resident. The Resident stop was transferred to the Medical Examine's office.  During an interview on at 10:56 AM the Psychiatrist reported he with the facility's staff and discussed residents' behaviors and if any adjustments are needed. When asked about Resident #1, the Psychiatrist reported he was not aware that Resident #1 had any behaviors. Upon discussion of the multiple documented pelsodes of afraidipanic noted on Resident #15 cinical record, the Psychiatrist reported he was not aware that Resident #1 had any behaviors.	TATEMENT C	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				-	(X3) DATE COMP	SURVEY LETED
CORAL REEF SUBACUTE CARE CENTER LLC  SUMMARY STATEMENT OF DEFICIENCIES (REACH DEFICIENCIES) (REACH DEFICIENCY MUST BE PRECEDED BY PLLL TAG (RECULATORY OR LSC IDENTIFYING INFORMATION)  (F 689)  Continued From page 58 (Staff C) LPN was scheduled to start her shift at 7:00 PM, no indication that she checked on Resident #1 from the time her shift started until the CNA called her at around 8:15 PM. At 8:15 PM, the CNA tried to get into the room and noted that the door was closed. The CNA three to open the door, but it was blocked. Staff A was in the room for a few second, leaves the area gets the rurse and the crash cart The Regional nurse explained that the CNA had to push the door open and when he entered, the room he noted Resident #1 seated in his wheelchair, unresponsive with a bag over his The CNA stated that he pulled the bag off Resident #1's and ran to get help. A code was called as well as 911, staff responded to this resident's room where they transferred him to the bed, a backboard was placed, and initiated. Law enforcement and EMTs responded shortly thereafter and pronounced this Resident. The Residents body was transferred to the Medical Examiner's office.  During an interview on at 10.56 AM the Psychiatrist reported he did not review the above mentioned behavior monitoring sheets in Resident #1, the Psychiatrist reported he was not aware that Resident #1 had any behaviors. Upon discussed residents' behaviors and if any adjustments are needed. When asked about Resident #1, the Psychiatrist reported he was not aware that Resident #1 had any behaviors. Upon discussed residents' reported he was not aware that Resident #1 had any behaviors. Upon discussion of the multiple documented pelsodes of afraidipanic noted on Resident #1's clinical record, the Psychiatrist reported he was not			105910	B. WING					
CORAL REEF SUBACUTE CARE CENTER LLC  (C4) ID  SUMMARY STATEMENT OF DEFICIENCIES  (RECULATORY OR LSC IDENTIFYING INFORMATION)  (RECULATORY OR APPROPRIATE  (REGULATORY OR LSC IDENTIFYING INFORMATION)  (RECULATORY OR APPROPRIATE  (REGULATORY OR LSC IDENTIFYING INFORMATION)  (RECULATORY OR APPROPRIATE  (REGULATORY OR APPROPRIAT	NAME OF PE	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
FEED   FREGULATORY OR LSC IDENTIFYING INFORMATION    PREFIX   FAGO   CROSS-REFERENCED TO THE APPROPRIATE   CROSS-REFERENCED TO THE APPROPRIST   CROSS-REFERENCED TO THE APPROPRIST   C	CORAL RI	EEF SUBACUTE CARE O	ENTER LLC		1				
(Staff C) LPN was scheduled to start her shift at 7:00 PM, no indication that she checked on Resident #1 from the time her shift started until the CNA called her at around 8:15 PM. At 8:15 PM, the CNA called her at around 8:15 PM. At 8:15 PM, the CNA cheld be get into the room and noted that the door was closed. The CNA tried to open the door, but it was blocked. Staff A was in the room for a few second, leaves the area gets the nurse and the crash cart The Regional nurse explained that the CNA had to push the door open and when he entered, the room he noted Resident #1 seated in his wheelchair, unresponsive with a bag over his The CNA stated that he puilled the bag off Resident #1's and ran to get help. A code was called as well as 911, staff responded to this resident's room where they transferred him to the bed, a backboard was placed, and initiated. Law enforcement and EMTs responded shortly thereafter and pronounced this Resident. The Residents body was transferred to the Medical Examiner's office.  During an interview on at 10:56 AM the Psychiatrist reported he did not review the above mentioned behavior monitoring sheets in Resident #1's clinical record. The Psychiatrist exportand that he met with the facility's staff and discussed residents' behaviors and if any adjustments are needed. When asked about Resident #1 had any behaviors. Upon discussion of the multiple documented episodes of afraidipanic noted on Resident #1's clinical record, the Psychiatrist reported he was not	PREFIX	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE		COMPLETION
aware and that the nurses had not communicated	{F 689}	(Staff C) LPN was sct 7:00 PM, no indication Resident #1 from the the CNA called her at the CNA called her at the CNA called her at the door, but it was bi room for a few second on the door, but it was bi room for a few second on the control of t	reduled to start her shift at that she checked on time her shift started until around 8:15 PM. At 8:15 get into the room and noted etc. The CNA thied to open cocked. Staff A was in the d, leaves the area gets the art The Regional nurse A had to push the door tered, the room he noted his wheelball, and the she was called as onded to this resident #1's elp. A code was called as onded to this resident #1's efforted him to the bed, a d, and initiated. Law is responded shortly need this Resident. The ransferred to the Medical had not review the avior monitoring sheets in record. The Psychiatrist with the facility's staff and behaviors and if any ed. When asked about chairtist reported he was not £1 had any behaviors. Upon liple documented episodes on Resident #1's clinical st reported he was not	<b>(F €</b>	589				

that the facility staff should have communicated , afraid/panic episodes and any other

		ID HUMAN SERVICES					M APPROVED
		MEDICAID SERVICES					O. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		LE CONSTRUCTION	COM	E SURVEY PLETED
		105910	B. WING				R-C /02/2021
NAME OF PE	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
				1	9869 SW 152ND STREET		
CORAL RI	EEF SUBACUTE CARE O	CENTER LLC			MIAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
(F 689)	behavior exhibited by tell me I would definite unreas usually call me those episodes. Had definitely done somet see him, maybe chan Residents who have a see him, maybe chan Residents who have a see him, maybe chan defective plan of care implementing policies risk factors and chang well as side effects an medications. The Administrator/ Die ducated facility staff including Licensed Ni. Services regarding be emphasis on monitor and identifying possible ris and behavior a Administrative staff or regarding neg and behavioral health Social services and n on a one-to-one basis informed car questionnaire regarding requestionnaire regarding requestionnaire regard Newly hired staff will informed car questionnaire regard Newly hired staff will informed car questionnaire regard.	Resident#1 to him. "If they ely do something. The They did not tell me about 1 known, I would have hing. I would have hing. I would have hing. I would have gone to ge the medication"  plan included: a diagnosis of and ted to ensure they have an in conjunction with and procedures to identify ge in and behavior as defectiveness of these rector of Nursing (DON) on a one-to-one basis ursing Staff, and Social shavioral health with ing residents prescribed medications and sk factors and changes in s well as side effects serviced all staff on a arding and Neglect. consultant will in-service a a one-to-one basis lect informed care in ursing staff were educated as by Administrator/DON on e including a newly added ng newly	₹F €	589)			
		onitor for behaviors related to					

and . . , and any noted side

		ID HUMAN SERVICES MEDICAID SERVICES					M APPROVED 0. 0938-0391
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI		LE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		105910	B. WING	_		11)	02/2021
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
CODAL D	EEF SUBACUTE CARE O	CENTED I I C			9869 SW 152ND STREET		
CORAL K	EEF SUBACUTE CARE C	SENTER ELC			MIAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPT DEFICIENCY)	BE	(X5) COMPLETION DATE
(F 689)	effects of medication as well as an affective plan of ce implementing policies risk factors and chang well as side effects at medication and to ensure a consideration and and monitored. Data will be month then monthly for the next two quart Services/designee wis screening on all activity implement a compret the facility's removal who are prescribed medication.	and informed care.  coted an audit of all active  losis of and  rerescribed  action to ensure they have  are in conjunction with  and procedures to identify  ge in and behavior as  and effectiveness of these  sure behavior monitoring  direflect the behaviors of  side effects are monitorind  iff audit 100% of all active  losis of and  ensure behavior sheets  behaviors, that those  entitions placed to intervene  any side effects of  medications are  be collected weekly for a  or  or  en collected weekly for a  or  er  er esidents.  Is failure to develop and  bensive care plan:  Is secribed,   medication  and  bensive care plan:  Is escribed,  benedication  benedica	⟨F €	8889	9)		

The Administrator/DON educated facility staff on a one-to-one basis including Licensed Nurses,

CENTERS FOR MEDICARE &							APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL' A. BUILDI	TIPLE CONSTRUC	TION		(X3) DATE S COMPL	URVEY
	105910	B. WING				R-1	C 2/2021
NAME OF PROVIDER OR SUPPLIER			STREET ADDR	RESS, CITY, STATE, ZIP CODE			
			9869 SW 152	ND STREET			
CORAL REEF SUBACUTE CARE O	CENTER LLC		MIAMI, FL 3				
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORF EACH CORRECTIVE ACTION S ROSS-REFERENCED TO THE AID DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
are prescribed medications to effective effectiveness of the m Minimum Data Set (M will conduct a one-to-staff and will conduct staff regarding developlan of care. The Administrator/DC a one-to-one basis in Staff. Certified Nusini following the care pla in order to effect symptoms. MDS conduct a one-to-one and will conduct an Ir regarding developing care. Newly hired staff will DON/designee during who are prescribed and medication in monitor for the effectiand side effects. An audit of all active the was conducted to effective and side effects of the Monitoring for Correc The DON or designee residents who are on and in medication in monitor for the effectiand side effects of the Monitoring for Correc The DON or designee residents who are on and in medication have been developed to the medication have been developed the medication have ben	es on developing and no regarding residents who no regarding residents who and vely monitor for the neclication and side effects. ADS) Corporate consultant come Inservice with MDS an Inservice with nursing sping and implementing a DN educated facility staff on cluding Licensed Nursing ga Aides on developing and in of Residents who have lively manage the Residents Scorporate consultant will inservice with MDS staff service with nursing staff and implementing a plan of the educated by the gorientation on residents medications to effectively veness of the medication residents who are on and medication residents who are on and medication stream of the properties of the medication residents who are on and medication sure a care plan has been ally monitor for effectiveness emedication:	₹F €	89)				

Data will be collected weekly for a month then twice a week for one quarter then monthly for the

MEDICAID SERVICES					
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(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					LETED
105910	B. WING	_			02/2021
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ENTERLIC			9869 SW 152ND STREET		
ENTERELL			MIAMI, FL 33157		
TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG				(X5) COMPLETION DATE
62	{F €	389	9)		
lazards, Supervision ded adequate supervision ded adequate supervision dedictively monitored to ges in and sremoval plan indicated: diagnosis of and ed to ensure behavior identify behaviors, intervene with the smade for illustrons. Ne ducated facility staff on luding Licensed Nurses, and Social Services nealth with emphasis on with emphasis on with emphasis on including a newly added by Administrator/DON on including a newly added by a many staff was educated by Administrator/DON on including a newly added by a many staff was educated during rat health with emphasis on with an and and the staff or one.					
The state of the s	(xt) PROVIDERGEUPPLEBOLLA DENTIFICATION NUMBER 105910  ENTER LLC  TEMENT OF DEFICIENCIES MUST BE PRECEDED BY PULL SCIDENTIFYING INFORMATION)  62  Lazards, Supervision ide adequate supervision ectively monitored to ges in and ectively monitored to ges in and ed to ensure behavior identify behaviors, intervene with the smade for , luations. Intervene with the smade for , luations. Intervene with the smade for , luations intervene with the smade for , luations and the smade for , luations and the smade for , luations. Intervene with the smade for , luations and the smade for ons. I are referrals are made for ons. I are the smade for ons the smade for the small health with emphasis on ith , and , re referrals are made for ons. I called an audit of all active behaviors of the rais for mental health are all from the audit. The DON	(X1) PROVIDERGEUPPLEPACIA (X2) MUL A BULD 105910  B. WING 105910  B. WING ENTER LLC  TEMENT OF DEFICIENCIES MUST BE PRECEDED BY PULL ECOENTRYING INFORMATION)  62  [A COENTRY OF THE PROVIDED BY PULL EXIST OF THE PRECEDED BY PULL EXIST OF THE PULL EXIST OF THE PRECEDED BY PULL EXIST OF THE PRECEDED BY PULL EXIST OF THE PULL EXIST	(X2) MILITIE (X2) MILITIE (X3) MILITIE (X4) MILITIE (X4) MILITIE (X5) MILITIE (X4) MILITIE (X5) MILITIE (X5) MILITIE (X6) MILITIE (X6) MILITIE (X7)	(X2) MULTIPLE CONSTRUCTION A BUILDING  105910  B. WING  STREET ADDRESS. CITY, STATE, ZIP CODE 980 SW 152ND STREET MAMI, F. 13157  TEMENT OF DEFICIENCIES MUST BE PRECEDED BY PULL COENTIFYING INFORMATION)  62  (F 689)  In PROVIDER'S PLAN OF CORRECTION (ROAD REPRECEDED BY PULL TAG CROSS-REFERENCED TO THE APPROPRIA	(X1) PROVIDERSUPPLIERCULA IDENTIFICATION NUMBER:    105910

resident's behaviors. Data will be collected weekly

		ID HUMAN SERVICES MEDICAID SERVICES					APPROVED 0. 0938-0391
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE	
		105910	B. WING				-C 02/2021
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
CORAL R	EEF SUBACUTE CARE O	CENTER LLC			9869 SW 152ND STREET WIAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
(F 689)	then monthly for the r Services/designee wi informed screening or The facility's removal onsite visit on interviews conducted Observations on residents with diagno and receiving me provided care and sei about the safety and were noted during ob On at 10- Administrator (NHA) is education and one to staff to ensure staff w knowledgeable. The I-60 employees to inc documenting of any s assessed and identific and to provide the behavior monitoring is Review of the Educa provided dated topics included: Documentation. Prog sheets. Monitor for for and prescribed medications effective informed Care,	e a week for one quarter ext two quarters. Social i conduct the iconduct the nall active residents. I plan was verified during an and telephone on revealed sampled sist of or of dication were being virious and no concerns well-being of the residents servations.  30 AM, the Nursing Home stated that she provided one training was provided to all full the training was provided to all full the monitoring and intuation with residents of concern formation on the heets.  Ion/In-Services logs until Monitoring, residents and behavior Monitoring residents and Monitoring residents.	{F €	689)			

factors and changes in and behavior. Able to identify side effects of . . . . . . . . and

		ID HUMAN SERVICES					APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0.0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIP	PLE CONSTRUCTION	(X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	iNG	š	COMP	LETED
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		105910	B. WING			11/	02/2021
NAME OF PE	ROVIDER OR SUPPLIER			Г	STREET ADDRESS, CITY, STATE, ZIP CODE		
					9869 SW 152ND STREET		
CORAL RI	EF SUBACUTE CARE O	ENTER LLC			MIAMI, FL 33157		
				L			,
(X4) ID		ATEMENT OF DEFICIENCIES	1D		PROVIDER'S PLAN OF CORRECTION	_	(X5) COMPLETION
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		DATE
IAG	The Cooper of the Cooper	SO IGENTIA PAGO PA GAMATIGITA	ind		DEFICIENCY)		
			-		-		
(F 000)							
(F 689)	Continued From page		{F €	689	9}		
		ns. Referral for mental					
	health evaluation. Ca	re Plan: , , ,					
		to effectively					
	monitor for effectivene						
	effectsDocume	ntation accuracy developing					
		ans for residents who have					
		ively manage their and					
		entifysymptoms and					
		e resident's Review of					
		ducation/In service dated					
	provided						
		ant, Director of Nursing.					
		ice logs dated to					
		education was provided to					
	75 nursing staff. On						
		by the three staff members					
		Department. (3 staff from					
		rtment), MDS and Care					-
		in-service was					
	provided to 8 staff me						
	staff) and (1 sta						
	in-service was provide	ed to new hires.					
		gs revealed weekly audits					
	for residents who are	on					
	, and ,	medication and side effects					
	of the medication.						
	Record review of the	facility's Policy and					
	Procedures for Care I	Plans, Comprehensive					
	Person-Centered was	revised on					
	The Resident I	Neglect and ,					
	Policy 1-800-96-						
		ly's Behavioral Assessment,					
	Intervention and Mon						
		wed with no concerns. The					
		Informed Care revised					
	recently a policy 101 .	ormed Care revised	1				

was reviewed.

		ID HUMAN SERVICES			FORM APPROVED
TATEMENT (	S FOR MEDICARE & I OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
		105910	B. WING		R-C 11/02/2021
	ROVIDER OR SUPPLIER EEF SUBACUTE CARE O	ENTER LLC	1 :	STREET ADDRESS, CITY, STATE, ZIP CODE 9869 SW 152ND STREET MIAMI, FL 33157	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
{F 689}	and 34 Certified Nurs and the te revealed to to the facility's staff a to explain understand received in the training	with 21 licensed nurses ing Assistants between lelephone interviews on that the inservices provided nd that the staff were able ing of the education gs provided.	{F 689		
F 711 SS=D	CFR(s): 483.30(b)(1): §483.30(b) Physician The physician must- §483.30(b)(1) Review of care, including me- each visit required by section; §483.30(b)(2) Write, s notes at each visit; ar	Visits  r the resident's total program flications and treatments, at paragraph (c) of this sign, and date progress d	F 711		
	exception of , which may physician-approved it assessment for contra This REQUIREMENT by: Based on interview a facility failed to ensure care needs was adeq psychiatrist for one (fresidents sampled as to effectively monitor behaviors related to F. and	acility policy after an		F711 Resident #1 no longer resides in the facility The Administrator/designee educated Licensed Nurses and Certifled Nursin Aides on the policy; Physician Service regarding notification to providers of changes in Resident's behaviors to ot a Mental Health Referral.	·S -

led to Resident #1 while unsupervised in his room

All Residents who are being monitored for

		ID HUMAN SERVICES					M APPROVED
		MEDICAID SERVICES					D. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI		CONSTRUCTION	COM	SURVEY
		105910	B. WING _				R-C /02/2021
NAME OF P	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE		
				98	69 SW 152ND STREET		
CORAL R	EEF SUBACUTE CARE (	CENTER LLC		M	IAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F711	placing a trash bag o by as a practice. There were medicatic receiving the facility at the time of the survey posed it health and safety of a facility.  The Findings Include. Record review of the and procedures tilled general statement no medications include a activities associated a cativities associated a cativities associated a cativities associated a cativities associated a the procedures tilled general statement including and drugs. Physicians an Physician Assistant, I medicat with the interdisciplin appropriate use, eval Standards included: goal of determining th behavioral symptoms treatment of environn behavioral interventic psychopharmacologic utilized to meet the O. Psychopharmaco used to enhance the used to enhance the used of enlierer buse used to enhance the used to enhance the and will neiver buse	d suffocated himself by ver hisresulting inresult of the deficient 17 residents receiving nas and 47 residents receiving nas and 47 residents medications residents medications residents medications residents admitted to the lit resident admitted to the little reside	F	711	behaviors due to a diagnosis of , , or those prescrib, , medication have the potential to be affected.  Resident's clinical records were reviet to note those with a diagnosis of , , and for those Residents prescribed a , , medication to ensure that behavior monitoring is in place, monitored and reported to the provider for a potential Mental Health Referral as warranted it to ensure the resident's mental health care needs are adequately supervise a psychiatrist/psychologist  Policies: Physician Services and Behavior Health Services were reviev The Administrator/designee educated Licensed Nurses and Certified Nursin Aides on the Physician Services policies and Behaviorat Health Policy The Administrator/designee educated licensed nurses and Certified Nursin Aides on ethal and the provider of an are prescribed , medication, is monitored for new or worsening behaviors. If a New or Worsening behavior is identified, those behaviors be reported to the provider for a poter Mental Health referral as warranted a ensure the resident's mental health c.	and in the state of the state o	
	utilized to meet the ne G. Psychopharmaco used to enhance the	eeds of individual resident. logical medications will be quality of life for the resident d for the purpose of			be reported to the provider for a poter Mental Health referral as warranted a ensure the resident's mental health or	ntial nd to are	

Procedures followed by the Primary Care

Physician, PA [Physician's Assistant], or NP

orientation regarding residents with

diagnosis of .... and/or

		D HUMAN SERVICES MEDICAID SERVICES					APPROVED 0.0938-0391
TATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDE		CONSTRUCTION	(X3) DATE COMP	
		105910	B. WING				02/2021
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CORAL R	EEF SUBACUTE CARE O	ENTER LLC			869 SW 152ND STREET NAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC (DENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F711	[Nurse Practitioner] N rationale and diagnos target symptoms. 4.1 interdisciplinary team — medical initiating, increasing, during routine visits it Procedures Follower health included: 1. establishing appropriate obsequence of the medications. 5. Helpmanagement plans. Procedures Follower health included: 1. establishing appropriate of the medications. 5. Helpmanagement plans. Procedures Follower 1. Monitors any adverse effects a somnolence or functic 2. Will monitor for the behaviors on a daily to documented as warra 3. Reviews the use of hysician and the intequarterly basis to determine the presence of target be of any adverse effect 4. [ will be performed on a querotte to the physic 5. develop behaling individualized non-ph	oted: 2. Documents is of the use and identifies 'evaluates with the effects, and side effects of ions within 14 days of or decreasing dose and sereafter.  by the Psychiatrist / mental , assist the facility in the guidelines for use, g of , , , s develop behavior  by Nursing: , drug use daily, noting uch as increased and decline. presence of target assis. Behaviors will be nted. the medication with the rdisciplinary team on a remine the continued havior and or the presence s of the medication use.  any resident and on arterly basis change will be lan. iovaria care plans that include armacological interventions. rdinates the interdisciplinary loral care plans that include armacological interventions. rdinates the interdisciplinary	F	711	and are prescribed	d to re  see  lits and	

Record review of Resident #1's behavior

		ID HUMAN SERVICES MEDICAID SERVICES						APPROVED . 0938-0391
TATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION		(X3) DATE	
		105910	B. WING	_			R-	C 02/2021
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	П	STREET ADDRESS, CITY, STATE, ZIP CODE			
				1	9869 SW 152ND STREET			
CORAL R	EEF SUBACUTE CARE (	CENTER LLC		L	MIAMI, FL 33157			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE		(XS) COMPLETION DATE
F711	and was monitored for the Related to the use of (mg) tablet. There was Resident #1 was mor behavior such as self. There was no behavior such as the showed that Resident #1 had a to Afraid/Panic. Five ou occurred during the hon 1,12,20 episodes of Afraid/Panic. Five out occurred during the hours of 7:00 PM to 7 and 28. The documer episoden orded "Routin Review of the nurses month of , s addressed any of the exhibited by Residen Review of the behavior monitoring s blank) for shift (7:00 AM to 7:00 AM to 7:00 AM to 7:00 AM to 7:00 AM shift. Thors of the New Short of 1:00 AM shift. Thors of 1:00 AM shift. Thors of the New occurre of the occurrence of the officer of 1:00 AM shift. Thors of the New occurrence of the occurrence of the officer of 1:00 AM shift. Thors of the New occurrence of the occurrence of the officer of 1:00 AM shift. Thors of the New occurrence of the occurrence occurrence of the occurrence occurren	diciated that Resident # 1 s behaviors atraid/panic. 1 milligram is no record to indicate that iltored for any other changes or danger to ehavior record to indicate of for his diagnosis of e use of behavior monitoring sheets ## had multiple episodes did/Panic.* The behavior tated on indicated al of 9 episodes of of nine different episodes ours of 7:00 AM to 7:00 PM and 25. Four different inci occurred between the '90 AM, on 27 trated interventions for each ne." progress notes for the howed no record that episodes of ##1 or sheets for led date of but the heet showed no record (left and during the day PM) on	F	711	1			

		ID HUWAN SERVICES					APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0.0938-0391
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		105910	B. WING			1	02/2021
NAME OF PE	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
CODAL DI	EEF SUBACUTE CARE (	CENTED I I C		98	69 SW 152ND STREET		
CORAL RI	EF SUBACUTE CARE	JENIER ELC		м	IAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 711	of the nurses' progres showed no recorded addressed any of the exhibited by Resident (init showed Resident #1 episodes of Afraid / Part of Afraid/Panic occurred PM on documented noted "Four out Afraid/Panic occurred with the policy of the Afraid/Panic occurred the Afraid/Panic during the Tolo AM) on 20, 21, 24, 26, 27 and intervention noted "Review of Nurses No showed no recorded addressed the episoc by Resident #1.  Review of the behavious of the Afraid/Panic during the Afraid/Panic of the Afraid/Panic of the PM on any episode of APM to 7:00 AM) on 11 that two episodes occurred during the during the Afraid/Panic pelsode of APM to 7:00 AM on 11 that two episodes occurred during the during the during the Afraid/Panic of PM on 11 that two episodes occurred during the durin	ss notes for documentation that ariad/panic episodes drainal/panic episodes drainal/panic episodes drainal/panic episodes drainal/panic episodes drainal panic during the month of 17 different episodes of 18 december 19 dec	F	711			
		ion that addressed any of					

the episodes exhibited by Resident #1.

		ID HUMAN SERVICES MEDICAID SERVICES					APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		PLE CONSTRUCTION  G	(X3) DATE COMP	
		105910	B. WING	_		11/	02/2021
NAME OF P	ROVIDER OR SUPPLIER			Г	STREET ADDRESS, CITY, STATE, ZIP CODE		
		THE LLO		ı	9869 SW 152ND STREET		
CURAL K	EEF SUBACUTE CARE O	SENTER ELC			MIAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 711	and record review with (DON), and the Clinic DON explained; the nomplete the behavior nurses are the ones the behavior to the behavior to the heavest experted and docume nursual for the patient might put the patient. The clinical records w Plan of care the DON , depends about anybody, the ccinclude provide emoit whatever they are into talk about their feel socialization, provide positive behaviors. N needed.  Review of the investig with the Clinical Regis approximately 2:30 P regional nurse had re	15 PM, during an interview hithe Director of Nursing al Regional Nurse. The nurses on the floor usually remolitoring heets. The hat monitor and document IA would report each s. Behaviors that are it and any behavior that in distress, such as were discussed related to the explained diagnoses of on the patient. For just are planned interventions onal support. Activities, erested in encouraging them lings. Encourage feedback to reinforce toolfy MD of changes as gative report and interventions on the patient of the	F	7*	11		
	observation of the videreviewed the video re Thursday last week." Saturday a CNA, [Staff A] went in #] at 4:18 PM. Nurse The Clinical Regional her going in and out of	leo and reported that she coording on "Tuesday or The report noted that on it 2:54 PM Resident #1's to the residents' room [room [Staff B] was passing meds. Nurse stated: "You can see of rooms." At 4:30 PM the baves Resident #1's room.					

The video showed that at 4:52 PM meal was delivered to Resident #1's room. His door

## PRINTED: 11/30/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES STA

DEPARTMENT OF HEALTH AN	ID HUMAN SERVICES		FORM APPROVED
CENTERS FOR MEDICARE &	MEDICAID SERVICES		OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
			R-C
	105910	B. WING	11/02/2021

			11/02/2021
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE	
	- 1	9869 SW 152ND STREET	
CORAL REEF SUBACUTE CARE CENTER LLC		MIAMI, FL 33157	
(XA) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG (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 APPROPRIATI DEFICIENCY)	(X5) COMPLETION DATE
			- 1
F 711 Continued From page 71 remained open the whole time. At 5:21 PM the Nurse [Staff B] went into Resident #1's room. At 5:43 PM the CNA [Staff A] picked up the tray, (Noted that he ate 100%). At 6:25 PM it appears the door is shut from inside the room. No one checked on the resident or attempted to enter the room from approximately 6:25 PM to 8:15 PM [Staff C], LPN was scheduled to start her shiff at 7:00 PM, no indication that she checked on Resident #1 from time her shift started until the CNA called her at around 8:15 PM. At 8:15 PM, the CNA tried to get into the room and noted that the door was closed. The CNA tried to open the door, but it was blocked. Staff A was in the room for a few second, leaves the area, gets the nurse and the crash cart The Regional nurse explained that The CNA had fo push the door opened and when he entered, the room he noted Resident #1 seated in his wheelchair, unresponsive with a bag over his The CNA stated that he pulled the bag off Resident #1's and ran to get help. A code was called as well as 911, staff responded to this resident's room where they transferred him to the bed, a backboard was placed, and initiated. Law enforcement and EMTs [Emergency Medical Tachnician] responded shortly thereafter and pronounced this Resident. The Residents body was transferred to the Medical Examiner's office.  On	F7	11	

		ID HUMAN SERVICES						M APPROVED
		MEDICAID SERVICES	T					0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONS	STRUCTION		(X3) DATE COMP	PLETED
			A. BUILD	ING				
			B. WING					t-C
		105910	B. WING				11/	02/2021
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE			
CODALD	EEF SUBACUTE CARE O	CENTERLIC		9869 SV	W 152ND STREET			
OOTHE IS	LEI GODAGGIE GAILE G	DENTER DEG		MIAMI,	FL 33157			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE		(X5) COMPLETION DATE
					DEFICIENCI)			
F 711	Continued From page	72	F					
	#1 was on isolation p	recautions due to a,						
	( ).	Staff B, RN stated: " I						
	worked from Thursda	y, to						
	Saturday	I monitored for						
		nis use of , . , we						
		, fear, or, I don't						
	remember him having							
		a little upset with the CNAs,						
		the door, close the window,						
		e! Generally, I document if						
		is constant. Normally, he						
	was easily re-directed							
		heet for the resident on the						
	days that I worked. I							
		day that he						
	What I documented w	vas that he had one Staff B, RN explained that						
	Resident #1 kept aski							
		ent. The intervention, during vas teaching about the						
		ent, what was the reason,						
		I in isolation. Staff B stated						
	that her documentation							
		out the afraid/panic episode						
	was related to the							
		the treatment and that it						
		stated: "I did not document						
		at the resident was having						
		ecause I did my action, I did						
		sperate, he allowed me to						
		tment." Staff B reported that						
		havior monitoring sheet is to						
		d medication,						
	and document the ep							
		e resident is taking the						
	medication. The inter-	vention was to refer to						

nurses' notes. Staff B agreed there was no record to explain anything about the resident's

behavior. Staff B stated: " It's established that a

## PRINTED: 11/30/2021 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES STA

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						11/02	72021
NAME OF PE	ROVIDER OR SUPPLIER			Г	STREET ADDRESS, CITY, STATE, ZIP CODE		
CODAL DI	EF SUBACUTE CARE O	CENTED I I C			9869 SW 152ND STREET		
CORAL RI	EF SUBACUTE CARE C	CENTER ELC		1	MIAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ΊX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 711	Continued From page patient can have at le , we take actio ones we would docur The purpose of the bt to see if the medicatic throughout the month monitoring sheet show effective. I document monitoring sheet show effective. I document agreed that the docur the exact nature, or did not know and cou Staff B stated: I also or 10th. 26th. When I noticed to anyone. I did not the communicate it to the monitor him for any or with a diagnosis of that she would have read a seemed well, he did not reject care, or cor discussion of Resider reported: "I am surprof	arast three small episodes of on if they have a big one. Big nent on the nurses' notes, shavior monitoring sheet is on seems effectivewhat the behavior was is that the medication is ad that he hadon and 4th. The one episode tething like, "I don't want to the behavior." Staff B then mentation does not reflect etails of the behavior, she lid not recall the behavior of cocumented no behavior on cocumented no behavior on tith, 16th, 17th, 24th, 25th, the behavior, I did not treport intik that I needed to psychiatrist. We did notidignoses of "Staff B explained eacted differently and that very dangerous, levels of 's can change and crisis."On that day he not seem depressed. He did mplaint of" Upon it #1's Diagnoses, Staff B issed that he had diagnosis sed that he had diagnosis		71	DEFICIENCY)		

		ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 11/30/2021 M APPROVED O: 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	COM	E SURVEY PLETED
		105910	B. WING			R-C /02/2021
NAME OF P	ROVIDER OR SUPPLIER		_	STREET ADDRESS, CITY, STATE, ZIP CODE		
CORAL R	EEF SUBACUTE CARE O	CENTER LLC		9869 SW 152ND STREET MIAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		OULD BE	(X5) COMPLETION DATE
F 711	the Psychiatrist reportable above mentioned bet Resident #1's clinical explained that he midiscussed residents 1's clinical explained that he midiscussed residents 1's adjustments are need Resident #1'. The Psyc aware that Resident fidiscussion of the multiple of a fraid/panic noted record, the Psychiatria aware and that the rich the behavior so him that the facility istaff significant to the psychiatria aware and that the rich that the facility istaff significant to the psychiatria aware and that the rich that the facility istaff significant that the facility istaff significant through the psychiatria aware and the second through t	at 10:56 AM teted he did not review the lawlor monitoring sheets in record. The Psychiatrist with the facility's staff and behaviors and if any led. When asked about chilatrist reported he was not if had any behaviors. Upon lipte documented episodes on Resident #1's clinical st reported he was not be a strength of the was not a	F (F 2	711		

accordance with the facility assessment required

		ID HUMAN SERVICES MEDICAID SERVICES			FORM APPR OMB NO. 0938	
STATEMENT	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		105910	B. WING		R-C 11/02/202	21
NAME OF P	ROVIDER OR SUPPLIER		8	TREET ADDRESS, CITY, STATE, ZIP CODE		
			9	869 SW 152ND STREET		
CORAL R	EEF SUBACUTE CARE	CENTER LLC	_ N	MAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMP	(5) LETION ATE
{F 726}	Continued From page	e 75	{F 726}			
	licensed nurses have and skill sets necessineeds, as identified thassessments, and de §483.35(a)(4) Providitimited to assessing,	cility must ensure that the specific competencies ary to care for residents' hrough resident scribed in the plan of care. or gare includes but is not evaluating, planning and et care plans and responding				
	to demonstrate comp techniques necessar needs, as identified it assessments, and de This REQUIREMENT by: Based on record rev facility failed to ensur providing adequate c	ure that nurse aides are able etency in skills and y to care for residents'		F726 Resident #1 no longer resides in the facility		
	received and implem informed care, accide monitoring of behavior with the Psy an English-speaking not fluent in the Engli diagnoses of , well as episodes of a unaddressed and/or decline and self-inflic facility's deficient pra of 10 residents samp	ent prevention, documenting, ors and communicating rchiatrist. Resident #1 was resident cared for by staff sh language. Resident #1's , , and , as		Nursing Staff Cared for resident #1 + 1 educated on informed Care, accident preventing, monitoring beha and communicating behavior with psychiatrist.  All Nursing staff were audited to ens they have been educated on informed Care, accident preventing, monitoring behavior, and communic behavior with psychiatrist Policies: informed Care, Accidents and Incidents – Investigating and Reporting Behavioral Health	vior, ure	

Services, Safety and supervision of

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				FORM	APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	. 0938-0391
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL' A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		105910	B. WING				-C 02/2021
NAME OF PE	ROVIDER OR SUPPLIER		_	5	TREET ADDRESS, CITY, STATE, ZIP CODE		OZ,ZOZ I
					869 SW 152ND STREET		
CORAL RI	EF SUBACUTE CARE O	CENTER LLC			MAMI, FL 33157		
(X4) ID		ATEMENT OF DEFICIENCIES	dt.		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
{F 726}	Continued From page	76	{F 7	26}			
	The findings included	:			residents were reviewed The Administrator/designee educated Nursing Staff on the above policies.		
	Record review of the	facility's assessment tool			The Administrator/designee educated		
	dated rev				Nursing Staff on the completion of		
		ved by qualified nursing			behavior monitoring sheets		
		e if needs can be met at the			The Administrator/designee educated		
	facility.	d. #0 f10t-d i-dt			Nursing Staff on monitoring behaviors,		
		d; "Our facility's resident thnic backgrounds, (ex:			and communicating behaviors with the psychiatrist/psychologist		
	Hispanics, whites, bla				informed care will be added to	the	
	Spanish, English, Cre				facility orientation and annual trainings		
		e needs included Mental			nursing staff.		
	Health and Behavior,	with Specific Care Practices			Behavioral health will be added to anni	Jal	
	to Manage the medical				trainings of Licensed Nursing Staff		
	medications-related is				The DON/designee will audit		
		ior, identify and implement			Behaviors sheets for accuracy and cor		
		support individuals with			documentation weekly X 4 then month 3	yХ	
		g with, care of			3		
		or other			The DON/designee will audit		
	diagnosis, intellectual				new admissions for Informed C	are	
					assessments weekly X 4 then monthly	X 3	
	Staffing Plan included	I, "Direct care staff is given			The DON/designee will audit all new		
		its to promote and establish			Nursing Staff for receiving education o	a	
	meaningful relationsh	ips with the residents and			Informed Care and behavioral		
		nel training competencies			Health weekly X 4 then monthly X 3		
		re. Including staff managers,					
	contract employees a	nd volunteers.			The DON/designee will report the resu	ts	
	Orientation is require	d for all names amplessed			of all audits to the QAPI committee for review and feedback.		
		d for all newly employed is and competencies are			review and reedback.		
		is and competencies are or all direct care staff			Responsible party: DON/Designee		
		npetencies are completed			Date of Compliance		
	on all direct care staff						
	During an interview w	ith the Director of Nursing					

(DON) on ... at 2:00 PM, the DON

DEPARTMENT OF HEALTH AN	ID HUMAN SERVICES			FORM APPROVE
CENTERS FOR MEDICARE & I	MEDICAID SERVICES			OMB NO. 0938-039
TATEMENT OF DEFICIENCIES NO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
				R-C
	105910	B. WING		11/02/2021
NAME OF BROWINGS OF SUBBLIED			CERTET AROUNDS OUT CYATE TRACORE	

NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
			9869 SW 152ND STREET			
CORAL R	EEF SUBACUTE CARE CENTER LLC		MIAMI, FL 33157			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
TAG (F 726)	·	(F 726)	DEFICIENCY)	Unite		
	the Social Services Assistant explained that a policy for informed care was recently padded to the scope of care the facility provided and, the facility have been in the planning and the facility have been in the planning and amissions Social Services started mid- or early to incorporate questions about stressful file experiences and					

## PRINTED: 11/30/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES STA

EFARTIVENT OF HEALTHAN	D HOWAIN SERVICES		FORM APPROVE
ENTERS FOR MEDICARE &	MEDICAID SERVICES		OMB NO. 0938-03
TEMENT OF DEFICIENCIES OPLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
	105010	R WANG	R-C

105910 11/02/2021

				_		117	02/2021
NAME OF P	ROVIDER OR SUPPLIER			Т	STREET ADDRESS, CITY, STATE, ZIP CODE		
CODALD	EEF SUBACUTE CARE O	SENTED I I C		1	9869 SW 152ND STREET		
CORAL R	EEF SUBACUIE CARE C	ENTER LLC			MIAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
(F 726)	their effect on resident the time that Residen facility, those question DON and the Social Facility did no life experiences and on life experiences and on the social Experienced.  Record review of Res Monitoring Sheets for about any past experienced.  Record review of Res Monitoring Sheets for and Resident # 1 was mon draid/panic. Related 1mg tablet. No record #1 was not monitored as changes or no behavior records t monitored for his diaguse of  Review of the behavior the resident had multiple for the sident was "Arfaid/Panic". For had a total of 9 epison of nine different episc hours of 7:00 AM to 7.20, and 25. Four diff Affaid/Panic occurred AM, on	It's and behavior. At ##1 was admittled to the savener has admittled to the savener has admittled to the savener has asked. The services Assistant revealed task about Resident #1's idi not ask if the resident experiences and added ared for him did not know. Resident # have have have have have have have have	₹F 7	726	5)		

		D HUMAN SERVICES					M APPROVED
CENTER	S FOR MEDICARE & I	MEDICAID SERVICES				OMB NO	0. 0938-0391
	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED R-C	
		105910	B. WING				02/2021
NAME OF P	ROVIDER OR SUPPLIER			Г	STREET ADDRESS, CITY, STATE, ZIP CODE		
CODAL D	EEF SUBACUTE CARE C	PENTEDLIC			9869 SW 152ND STREET		
CORAL K	EEF SUBACUTE CARE C	ENTERECO		ı	MIAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
{F 726}	no record (left blank) during the day shift indicating that the bet monitored during that behavior monitoring nf 11 had 15 different et during the evening sh Afraid/Panic behavior 10, 11, 13, 15, 16, 17, 29. The Nurses Prog showed no record that episodes of afraid/panic proposed from 17 different episodes of afraid/panic occurred month. Four out 17 di Afraid/Panic occurred of 1, 3, 4, an Routine QHS(Every hof 's behav showed that Resident different episodes of Avening shift (7PM-7 noted 'Refer to Nurses Progress Note Nurses Progress Note Addressed any of the exhibited by Resident The behavior occurred on 17, 19, 20, 21, 24, 26 horses any of the exhibited by Resident The behavior accurred on 17, 19, 20, 21, 24, 26 horses any of the exhibited by Resident The behavior accurred on 18 feet free episodes. Two occurred during the day and on the first proposed that the proposed of the proposed free free proposed so that the proposed free free proposed so the proposed free free free free free free free fr	for and AM - 7PM) of AM - 7PM) of AM - 7PM) of AM - 7PM of AM - 7P	{F :	7726	6)		

between 7PM - 7 AM on

Interventions for each episode noted "Routine

		ID HUMAN SERVICES MEDICAID SERVICES					M APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		105910	B. WING				I-C 102/2021
NAME OF PE	ROVIDER OR SUPPLIER	•			REET ADDRESS, CITY, STATE, ZIP CODE		
CORAL RI	EEF SUBACUTE CARE (	CENTER LLC			89 SW 152ND STREET AMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 726}	QHS." Review of the month of a shaddressed any of the Resident #1.  On at 8.4 Supervisor, Staff I revout the behavior mon a routine medication: check the number or medication check the number or medication was effect an episode of behavior such as tryic get up from the whee aggressive behavior the medications and tepisode happened is the intervention for who two two two two two two two two two tw	progress notes for the owed no record that episodes exhibited by perisodes exhibited by perisodes exhibited by perisodes exhibited by perisodes exhibited by perisodes. The manner of the perisodes of the perisodes, whether or not the live. Staff I explained that is if staff noticed a go go got out of bed, trying to lichair, if they show with the staff, if they throw the number of times that an recorded. Staff I stated that hen the routine medication is the psychiatrist for defent and follow orders and effects and observe for e effects. Staff I, RN umented on Resident #1's sheet on and on dit that she documented zero	₹F 7	226)			
		e day Resident #1 Staff Resident #1 was alert and					

liked to stay in his room alone with the door

IDENTIFICATION NUMBER:  105910  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 11702/202  SERVED SAME OF PROVIDER OR SUPPLIER  CORAL REEF SUBACUTE CARE CENTER LLC  SUMMARY STATEMENT OF DEFIDIENCIES (PAL) D. SUMMARY STATEMENT OF DEFIDIENCIES TAG  SUMMARY STATEMENT OF DEFIDIENCIES (PAL) D. SUMMARY STATEMENT OF DEFIDIENCIES (PAL) DEFIDIENCY MUST BE PRECEDED BY FULL REGULATORY ON USC IDENTIFYING INFORMATION)  (F 726)  Continued From page 81 closed and required assistance to go to bathroom and was on isolation precautions. Staff A, CNNA explained his schedule for that weekend; on Friday, he worked a double shift from 7:00 AM to 3:00 PM and from 3:00 PM to 11:30 PM. He continued on Saturday again work from 7:30 AM to 11:30 PM. Staff A reported that on the day of the incident, (	NAME OF F	OF DEFICIENCIES IF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA				
IDENTIFICATION NUMBER:  105910  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 11702/202  SERVED SAME OF PROVIDER OR SUPPLIER  CORAL REEF SUBACUTE CARE CENTER LLC  SUMMARY STATEMENT OF DEFIDIENCIES (PAL) D. SUMMARY STATEMENT OF DEFIDIENCIES TAG  SUMMARY STATEMENT OF DEFIDIENCIES (PAL) D. SUMMARY STATEMENT OF DEFIDIENCIES (PAL) DEFIDIENCY MUST BE PRECEDED BY FULL REGULATORY ON USC IDENTIFYING INFORMATION)  (F 726)  Continued From page 81 closed and required assistance to go to bathroom and was on isolation precautions. Staff A, CNNA explained his schedule for that weekend; on Friday, he worked a double shift from 7:00 AM to 3:00 PM and from 3:00 PM to 11:30 PM. He continued on Saturday again work from 7:30 AM to 11:30 PM. Staff A reported that on the day of the incident, (	NAME OF F	F CORRECTION				OMB N	IO. 0938-0391
NAME OF PROVIDER OR SUPPLIER  CORAL REEF SUBACUTE CARE CENTER LLC    SUMMARY STATEMENT OF DEFICIENCIES   SERVENT STATE SUPPLIES   SERVENT STATE SUBACUTE CARE CENTER LLC     DAI 10	NAME OF F		IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION		
I 105910 B. WING	(X4) ID PREFIX			A. BUILDI	NG	cor	MPLETED .
I 105910 B. WING	(X4) ID PREFIX						R-C
NAME OF PROVIDER OR SUPPLIER  CORAL REEF SUBACUTE CARE CENTER LLC    SIMMARY STATELEIST OF DEFICIENCES   D   PROVIDER'S PLAN OF CORRECTION   REGULATORY OR LSC IDENTIFYING INFORMATION    TAG   PROVIDER'S PLAN OF CORRECTION   REGULATORY OR LSC IDENTIFYING INFORMATION    TAG   PROVIDER'S PLAN OF CORRECTION   REGULATORY OR LSC IDENTIFYING INFORMATION    TAG   PROVIDER'S PREFIX   REGULATORY OR LSC IDENTIFYING INFORMATION    TAG   PROVIDER'S PREFIX   REGULATORY OR LSC IDENTIFYING INFORMATION    TAG   PROVIDER'S PREFIX   REGULATORY OR LSC IDENTIFYING INFORMATION    REGULATORY OR LSC IDENTIFYING INFORMATION    TAG   PROVIDER'S PROPRIATE   CROSS-REFERENCED TO THE APPROPRIATE   COMPANDED TO THE APPROPRIATE   COMPA	(X4) ID PREFIX		105910	B. WING		<b> </b>	
CORAL REEF SUBACUTE CARE CENTER LLC    MAIN TO   PREFIX   SUMMARY STATEMENT OF DEFICIENCIES   PREFIX   REGULATORY OR LIST DEFICIENCY MUST BE PRECEDED BY PULL   PREFIX   TAG   PROVIDER'S PLAN OF CORRECTION   PREFIX   PREFIX   PREFIX   PROVIDER'S PLAN OF CORRECTION   PREFIX   PREFIX   PREFIX   PROVIDER'S PLAN OF CORRECTION   PREFIX   PREFIX   PREFIX   PROVIDER'S PLAN OF CORRECTION   PREFIX   PREFIX   PREFIX   PREFIX   PROVIDER'S PLAN OF CORRECTION   PREFIX	(X4) ID PREFIX		.1		STREET ADDRESS CITY STAT		1) 02/202 (
CORAL REEF SUBACUTE CARE CENTER LC  (PA) ID  SUMMARY STATEMENT OF DEFIDIENCIES  BEACH DERICEMENT MUST BE PRECEDED BY FULL  RECOLATORY ON U.S. IDENTIFYING INFORMATION)  (F 726)  Continued From page 81  closed and required assistance to go to bathroom and was on isolation precautions. Staff A, CNA explained his schedule for that weekend; on Friday. he worked a double shift from 7.00 AM to 3:00 PM to 3:00 PM to 13:30 PM. Staff A reported that on the day of the incident, (	(X4) ID PREFIX	NO FIDER OF OUT DET				IL, EN GODE	
(F 726)  (F 726)  Continued From page 81 closed and required assistance to go to bathroom and was on isolation precautions. Staff A, CNA explained his schedule for that weekend; on Friday. Per worked a double shift from 7:00 AM to 3:00 PM and from 3:00 PM to 11:30 PM. Staff A reported that on the day of the incident, ( , ) he came _ from break which was from 8:00 PM to 8:30 PM. Staff A stated that during rounds he noticed that Resident #1's door would not open, and he pushed the door. Staff A stated that the thought the resident may have blocked the door who shift was staff and the the door, to noticed the resident was stitting on his chair with a plastic bag on his The wheelchair was locked. He normally had two trash containers, one on each side of his	PREFIX	EEF SUBACUTE CARE	CENTER LLC				
FREEN   REGULATORY OR LIST IDENTIFYING INFORMATION    FREEN TAG   REGULATORY OR LIST IDENTIFYING INFORMATION    TAG   CROSS-REFERENCED TO THE APPROPRIATE   CONF.	PREFIX	,			WRAWI, FL 33157		
F 726  Continued From page 81   F 726  Continued From page 81   F 726  Cossed and required assistance to go to bathroom and was on isolation precautions. Staff A, CNA explained his schedule for that weekend; on Friday, he worked a double shift from 7:00 AM to 3:00 PM and from 3:00 PM to 11:30 PM. He continued on Saturday to again work from 7:30 AM to 11:30 PM. Staff A reported that on the day of the incident, (							(X5)
(F 726) Continued From page 81 closed and required assistance to go to bathroom and was on isolation precautions. Staff A, CNA explained his schedule for that weekend; on Friday.  Ne worked a double shift from 7.00 AM to 3:00 PM and from 3:00 PM to 11:30 PM. He continued on Saturday again work from 7:30 AM to 11:30 PM. Staff A reported that on the day of the incident, (	183						DATE
closed and required assistance to go to bathroom and was on isolation precautions. Staff A, CNA explained his schedule for that weekend; on Friday.  Ne worked a double shift from 7:00 AM to 3:00 PM and from 3:00 PM to 11:30 PM. Staff A gagain work from 7:30 AM to 11:30 PM. Staff A reported that on the day of the incident, (		NEGOLATORT ON	LOC IDENTIF TING INFORMATION)	IAG			
closed and required assistance to go to bathroom and was on isolation precautions. Staff A, CNA explained his schedule for that weekend; on Friday.  Ne worked a double shift from 7:00 AM to 3:00 PM and from 3:00 PM to 11:30 PM. Staff A gagain work from 7:30 AM to 11:30 PM. Staff A reported that on the day of the incident, (		1					+
closed and required assistance to go to bathroom and was on isolation precautions. Staff A, CNA explained his schedule for that weekend; on Friday.  Ne worked a double shift from 7:00 AM to 3:00 PM and from 3:00 PM to 11:30 PM. Staff A gagain work from 7:30 AM to 11:30 PM. Staff A reported that on the day of the incident, (	(F. 700)						
and was on isolation precautions. Staff A, CNA explained his schedule for that weekend; on Friday.  1.00 AM to 3.00 PM and from 3.00 PM to 11.30 PM. He continued on Saturday  1.00 AM to 3.00 PM and from 3.00 PM to 11.30 PM. He continued on Saturday  1.00 AM to 11.30 PM. Staff A reported that on the day of the incident.  1.01 AM to 1.00 PM to 8.30 PM. Staff A stated that 1.01 AM to 1.00 PM to 8.30 PM. Staff A stated that 1.01 AM to 1.00 PM to 8.30 PM. Staff A stated that 1.01 AM to 1.00 PM to 8.30 PM. Staff A stated that 1.01 AM to 1.00 PM to 8.30 PM. Staff A stated that 1.01 AM to 1.00 PM to 8.30 PM. Staff A stated that 1.01 AM to 1.00 PM to 8.30 PM. Staff A stated that 1.01 AM to 1.00 PM to 8.30 PM. Staff A stated that he thought the resident may have 1.01 BM to 1.00 PM 1.01 AM to 1.00 PM to 1.00 PM to 1.00 PM 1.01 AM to 1.00 PM to 1.00 PM to 1.00 PM 1.01 AM to 1.00 PM to 1.00 PM 1.01 AM to 1.00 PM 1.01 A	{F 726}			{F 7	26}		
explained his schedule for that weekend; on Friday. he worked a double shift from 7:00 AM to 3:00 PM and from 3:00 PM to 11:30 PM. He continued on Saturday to again work from 7:30 AM to 11:30 PM. Staff A reported that on the day of the incident, (							
Friday, he worked a double shift from 7:00 AM to 3:00 PM and from 3:00 PM to 11:30 PM. He continued on Saturday to again work from 7:30 AM to 11:30 PM. Staff A reported that on the day of the incident, ( ) he came from break which was from 8:00 PM to 8:30 PM. Staff A stated that during rounds he noticed that Resident #1's door would not open, and he pushed the door. Staff A stated that he throught the resident may have blocked the door with something. Staff A: "When I finally opened the door, I noticed the resident was sitting on his chair with a plastic bag on his The wheelchair was locked. He normally had two trash containers, one on each side of his							
7.00 ÅM to 3:00 PM and from 3:00 PM to 11:30 PM. He continued on Saturday to again work from 7:30 AM to 11:30 PM. Staff A reported that on the day of the incident, (							
PM. He continued on Saturday to again work from 7:30 AM to 11:30 PM. Staff A reported that on the day of the incident, ( ) he came from break which was from 8:00 PM to 8:30 PM. Staff A stated that during rounds he noticed that Resident #1's door would not open, and he pushed the door. Staff A stated that he thought the resident may have blocked the door with something. Staff A' When I finally opened the door, I noticed the resident was sitting on his chair with a plastic bag on his The wheelchair was locked. He normally had two trash containers, one on each side of his							
again work from 7:30 AM to 11:30 PM. Staff A reported that on the day of the incident.  (							
reported that on the day of the incident, (							
( ) he came from break which was from 8:00 PM to 8:30 PM. Staff A stated that during rounds he noticed that Resident #1's door would not open, and he pushed the door. Staff A stated that he thought the resident may have blocked the door with something. Staff A: "When I finally opened the door, I noticed the resident was sitting on his chair with a plastic bag on his The wheelchair was locked. He normally had two trash containers, one on each side of his							
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during rounds he noticed that Resident #1's door would not open, and he pushed the door. Staff A stated that he thought the resident may have blocked the door with something. Staff A." When I finally opened the door, I noticed the resident was sitting on his chair with a plastic bag on his The wheelchair was locked. He normally had two trash containers, one on each side of his							
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I finally opened the door, I noticed the resident was sitting on his chair with a plastic bag on his The wheelchair was locked. He normally had two trash containers, one on each side of his							
was sitting on his chair with a plastic bag on his The wheelchair was tocked. He normally had two trash containers, one on each side of his							
The wheelchair was locked. He normally had two trash containers, one on each side of his							
had two trash containers, one on each side of his							
			ners, one on each side of his				
bed, with plastic bag inside of it. Once I opened							-
		bed, with plastic bag					
took the plastic bag; I threw it on the floor and		bed, with plastic bag the door, I noticed th	e plastic bag on his . I				
cried for help. The floor nurse was on the hallway.		bed, with plastic bag the door, I noticed th took the plastic bag;	e plastic bag on his . I I threw it on the floor and				
We went to get the crash cart, she called code		bed, with plastic bag the door, I noticed th took the plastic bag; cried for help. The flo	e plastic bag on his . I I threw it on the floor and oor nurse was on the hallway.				
		bed, with plastic bag the door, I noticed th took the plastic bag; cried for help. The flo We went to get the c	e plastic bag on his . I I threw it on the floor and oor nurse was on the hallway. wash cart, she called code				
the chair to the wheelchair, they initiated the		bed, with plastic bag the door, I noticed th took the plastic bag; cried for help. The flo We went to get the c blue, the nurse and I	e plastic bag on his . I I threw it on the floor and oor nurse was on the hallway, crash cart, she called code I transferred the resident from				
until the ambulance arrived The police arrived		bed, with plastic bag the door, I noticed th took the plastic bag; cried for help. The fic We went to get the c blue, the nurse and I the chair to the whee	re plastic bag on his . I I threw it on the floor and oor nurse was on the hallway, brash cart, she called code I transferred the resident from elchair, they initiated the .				
they interviewed me I could not leave the		bed, with plastic bag the door, I noticed th took the plastic bag; cried for help. The flc We went to get the c blue, the nurse and I the chair to the whee until the ambulance	le plastic bag on his I I threw it on the floor and oor nurse was on the hallway. trash cart, she called code I transferred the resident from elchair, they initiated the arrived The police arrived				
facility until after the detective interviewed me.		bed, with plastic bag the door, I noticed th took the plastic bag; cried for help. The fit We went to get the c blue, the nurse and I the chair to the whee until the ambulance a they interviewed me	le plastic bag on his I I threw it on the floor and oor nurse was on the hallway, rash cart, she called code I transferred the resident from elchair, they initiated the I arrived The police arrived I could not leave the				
During the interview, Staff A explained that		bed, with plastic bag the door, I noticed th took the plastic bag; cried for help. The flo We went to get the c blue, the nurse and I the chair to the whee until the ambulance of they interviewed me facility until after the	le plastic bag on his I I threw it on the floor and oor nurse was on the hallway. rash cart, she called code I transferred the resident from slothair, they initiated the arrived I could not leave the detective interviewed me.				
		bed, with plastic bag the door, I noticed th took the plastic bag; cried for help. The fit We went to get the c blue, the nurse and I the chair to the whee until the ambulance they interviewed me facility until after the During the interview.	le plastic bag on his . I I threw it on the floor and bor nurse was on the hallway. rash cart, she called code I transferred the resident from slchair, they initiated the arrived The police arrived I could not leave the detective interviewed me. Staff A explained that				
behaviors the selection are each as a behavioral		bed, with plastic bag the door, I noticed th took the plastic bag; cried for help. The fite blue, the nurse and I the chair to the whee until the ambulance they interviewed me facility until after the During the interview. Resident #1 Sometim	le plastic bag on his . I I threw it on the floor and oor nurse was on the hallway. rash cart, she called code I transferred the resident from elchair, they initiated the . arrived The police arrived I could not leave the detective interviewed me. Staff A explained that nes was aggressive and had				
behaviors like refusing care such as a haircut and		bed, with plastic bag the door, I noticed th took the plastic bag; cried for help. The fit We went to get the collection that the chair to the wheel until the ambulance they interviewed me facility until after the During the interview. Resident #1 Sometin behaviors like refusir sike sike sike sike sike sike sike sike	le plastic bag on his . I I threw it on the floor and orn rurse was on the hallway, rash cart, she called code I transferred the resident from sichair, they initiated the . arrived The police arrived I could not leave the detective interviewed me. Staff A explained that nes was aggressive and had ng care such as a haircut and				
refused to shave. Staff A reported that he had to		bed, with plastic bag the door, I noticed th took the plastic bag; cried for help. The fit We went to get the c blue, the nurse and I the chair to the whee until the ambulance they interviewed me facility until after the During the interview, Resident #1 Sometim behaviors like refusir	le plastic bag on his . I I threw it on the floor and oor nurse was on the hallway. rash cart, she called code I transferred the resident from sichair, they initiated the arrived I could not leave the detective interviewed me. Staff A explained that mes was aggressive and had no care such as a haircut and taff A reported that he had to				
refused to shave. Staff A reported that he had to convince Resident #1 and he allowed him to		bed, with plastic bag the door, I noticed the took the plastic bag; cried for help. The fit We went to get the colue, the nurse and I the chair to the whee until the ambulance of the interviewed me facility until after the During the interviewed me heading the interview. Resident #1 Sometin behaviors like refusir refused to shave. SI convince Resident #	le plastic bag on his . I I threw it on the floor and oor nurse was on the hallway, rash cart, she called code I transferred the resident from sichair, they initiated the . arrived The police arrived I could not leave the detective interviewed me. Staff A explained that mes was aggressive and had ng care such as a haircut and taff A reported that he had to I and he allowed him to				
refused to shave. Staff A reported that he had to convince Resident #1 and he allowed him to shave him. Staff A reported that not that long ago,		bed, with plastic bag the door. I noticed the took the plastic bag; cried for help. The fit We went to get the cobue, the nurse and I the chair to the whee until the ambulance a they interviewed me facility until after the During the interview. Resident #1 Sometim behaviors like refusir effused to shave. St convince Resident.	le plastic bag on his . I I threw it on the floor and bor nurse was on the hallway. rash cart, she called code I transferred the resident from slchair, they initiated the . arrived The police arrived I could not leave the detective interviewed me. Staff A explained that mes was aggressive and had ng care such as a haircut and taff A reported that he had to 1 and he allowed him to 2 ported that not that long ago,				
refused to shave. Staff A reported that he had to convince Resident #1 and he allowed him to		bed, with plastic bag the door, I noticed th took the plastic bag; cried for help. The fit We went to get the c blue, the nurse and I the chair to the whee until the ambulance they interviewed metadility until after the During the interview. Resident #1 Sometin behaviors like refusire fused to shave. SI convince Resident # shave him. Staff Are maybe two weeks Rt	le plastic bag on his . I I threw it on the floor and our nurse was on the hallway, rash cart, she called code transferred the resident from sichair, they initiated the . arrived The police arrived I could not leave the detective interviewed me. Staff A explained that mes was aggressive and had ng care such as a haircut and taff A reported that he had to 1 and he allowed him to sported that not that tong ago, seident #1 would sometimes				

reported that he reported the behavior to the floor nurse and asked the nurse to come to the room

		ID HUMAN SERVICES					APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION		PLETED
		105910	B. WING				-C 02/2021
NAME OF P	ROVIDER OR SUPPLIER			Ι.	STREET ADDRESS, CITY, STATE, ZIP CODE	1	
				١,	9869 SW 152ND STREET		
CORAL R	EEF SUBACUTE CARE O	CENTER LLC			MIAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
(F 726)	and help him translate that he (Staff A) here that there was no nee Resident #1 understo with the Clinical Regia approximately 2:30 P regional nurse had re recording as she inve Clinical Regional Nurobservation of the video re recording as she inve Clinical Regional Nurobservation of the video re Thursday last week." Saturday a CNA, [Staff A] went in #] at 4:18 PM. Nurse The Clinical Regional her going in and out of friend [Resident #4] le The video showed the video re remained open the will Nurse [Staff B] went it will be considered that he shall be consi	e and explain to Resident #1 to take care of him, and d to be aggressive and of and even apologized, yative report and interview onal Nurse on at M revealed, the Clinical viewed the facility's video stigated the event. The se documented her eo and reported that she cording on "Tuesday or The report noted that on t2:54 PM Resident #1's to the residents' room [com [Staff B] was passing meds. Nurse stated: "You can see foroms." At 4:30 PM the saves Resident #1 's room. At at 4:52 PM the hoto Resident #1's room. His door note time. At 5:21 PM the not Resident #1's room. At af 4:52 PM the hoto Resident #1's room. At and the time. At 5:25 PM to 8:15 PM heduled to start her shift at not attempted to enter the taly 6:25 PM to 8:15 PM heduled to start her shift at not the room and noted that The CNA tried to open the ed. Staff A was in the room es the area. gets the nurse	(F	726			

explained that The CNA had to push the door

CENTERS FOR MEDICARE &			D HUMAN SERVICES					APPROVED
IDENTIFICATION NUMBER:  105910    STREET ADDRESS, CITY, STATE, ZIP CODE				1				
INMEC OF PROVIDER OR SUPPLIER  CORAL REEF SUBACUTE CARE CENTER LLC  SUBMINATY STATEMENT OF DEFICIENCES  (EACH DEFICIENCY MUST BE PRECEDED BY PULL TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  (F 726)  Continued From page 83 opened and when he entered, the room he noted  Resident #1 seated in his wheelchair,  unresponsive with a bag over his The CNA  stated that he puiled the bag off Resident #1's  and ran to get help. A code was called as  well as 911, staff responded to this resident's  room where they transferred him to the bed, a  backboard was placed, and initiated. Law  enforcement and EMTs responded shortly  thereafter and pronounced this Resident. The  Residents body was transferred to the Medical  Examiner's office.  Ona1 10:01 AM, with Spanish  speaking Registered Nurse (RN), Staff B  revealed: she normally worked with Resident #1  three days a week from 7:00 AM to 7:00 PM. The  resident was aleft and oriented times three and  communicated his needs well. Staff B, RN was not able to  explain why the Medication Administration  Records (MAR) indicated zero for , level the  entire month of and Staff B  insisted that the resident did not have Y Those  last three days 's Staff B, RN stated.' 1  worked from Thursday, to worked from Thursday to saturday							COMP	LETED
CORAL REEF SUBACUTE CARE CENTER LLC    SUMMARY STATEMENT OF DEFICIENCIES   REACH DEFICIENCY MUST are PRECEDED BY FULL   PREFIX   REQUILATION Y OR US. DENTIFYING INFORMATION    PREFIX   TAG   PROVIDER'S PLAN OF CORRECTION (REACH CORRECTIVE ACTION SHOULD BE ORDER TO AND CORRECTION (REACH CORRECTIVE ACTION SHOULD BE ORDER TO AND CORRECTION SHOULD BE ORDER TO AND CORRECTION SHOULD BE ORDER TO AND CORRECTION (REACH CORRECTIVE ACTION SHOULD BE ORDER TO AND CORRECTION SHOULD BE ORDER			105910	B. WING				
CORAL REEF SUBACUTE CARE CENTER LLC  (PA) ID  SUMAMARY STATEMENT OF DEFICIENCIES  (PACH DEPICENCY MUST BE PRECEDED BY FULL RECOLATIONY OR LSC IDENTIFYING INFORMATION)  (F 726)  Continued From page 83 opened and when he entered, the room he noted Resident #1 seated in his wheelchair, unresponsive with a bag over his The CNA stated that he pulled the bag off Resident #1*s and ran to get help. A code was called as well as 911, staff responded to this resident's room where they transferred him to the bed, a backboard was placed, and initiated. Law enforcement and EMTs responded shortly thereafter and pronounced this Resident. The Residents body was transferred to the Medical Examiner's office.  On at 10:01 AM, with Spanish speaking Registered Nurse (RN), Staff B revealed; she normally worked with Resident #1 three days a week from 7:00 AM to 7:00 FM. The resident was alert and oriented times three and communicated his needs well. Staff B, RN was asked about Resident #1'. Staff B, RN was asked about Resident #1' had, at times; "I remember he did at some point take medications, and staff B insisted that the resident did not have the last times she cared for him (Thursday, to Saturday ). "Those last three days he did not have staff B explained that on the day of the incident Resident #1 was on isolation precautions due to a (). Staff B, RN stated: "I worked from Thursday, to Saturday ) monitored for behaviors related to his use of we explained that on the day of the incident Resident for Saturday inmonitored for behaviors related to his use of we explained that on the day of the incident Resident	NAME OF PR	ROVIDER OR SUPPLIER			1			
DANID PREFIX (EACH DEFICIENCY NUTS TEATHERN TO F DEFICIENCIES (EACH DEFICIENCY NUTS TEATHERN TO F DEFICIENCY STATE BY RECOLATORY OR IS.O IDENTIFYING INFORMATION)  (F 726)  Continued From page 83 opened and when he entered, the room he noted Resident #1 seated in his wheelchair, unresponsive with a bag over his The CNA stated that he pulled the bag off Resident #1 stated the bag off Resident #1 stated that he pulled the bag off Resident #1 stated that he pulled the bag off Resident #1 stated that he pulled the bag off Resident #1 stated that he pulled resident #1 stated that he pulled resident #1 stated shortly thereafter and pronounced this Resident #1 three days a week from 7:00 AM to 7:00 FM. The Residents body was transferred to the Medical Examiner's office.  On , at 10:01 AM, with Spanish speaking Registered Nurse (RN), Staff B revealed; she normally worked with Resident #1 three days a week from 7:00 AM to 7:00 FM. The resident was altert and oriented times three and communicated his needs well. Staff B, RN was asked about Resident #1 , Staff B, RN was asked about Resident #1 , Staff B, RN was asked about Resident #1 , Staff B, RN was not able to explain wity the Medication Administration Records (MAR) indicated zero for level the entire month of and Staff B insisted that the resident did not have the last times she cared for him (Thursday, to Saturday	CODAL D	TEE CURACUTE CARE	SENTED LLC			9869 SW 152ND STREET		
FREENE TAG RECOLATORY OR US CIDENTIFYING INFORMATION)  (F 726)  Continued From page 83 opened and when he entered, the room he noted Resident #1 seated in his wheelchair, unresponsive with a bag over his The CNA stated that he pulled the bag off Resident #1 stated the bag off Resident #1 shaded in his wheelchair, or own where they transferred him to the bed, a backboard was placed, and initiated. Law enforcement and EMTs responded to this resident's room where they transferred him to the bed, a backboard was placed, and initiated. Law enforcement and EMTs responded shortly thereafter and pronounced this Resident. The Residents body was transferred to the Medical Examiner's office.  On , at 10:01 AM, with Spanish speaking Registered Nurse (RN), Staff B revealed; she normally worked with Resident #1 three days a week from 7:00 AM to 7:00 PM. The resident was alert and oriented times three and communicated his needs well. Staff B, RN was asked about Resident #1', Staff B, RN acknowledged that Resident #1 had, at times; "I remember he did at some point take medications, and For about three days" Staff B, RN was not able to explain wity the Medication Administration Records (MAR) indicated zero for, level the entire month of and Staff B insisted that the resident did not have, the last times she cared for him (Thursday, to Saturday	CURAL RI				L	,		,
opened and when he entered, the room he noted Rosident #1 seated in his wheelchair, unresponsive with a bag over his The CNA stated that he pulled the bag off Resident #1's and ran to get help. A code was called as well as 911, staff responded to this resident's room where they transferred him to the bed, a backboard was placed, and Initiated. Law enforcement and EMTs responded shortly thereafter and pronounced this Resident. The Residents body was transferred to the Medical Examiner's office.  Onat 10:01 AM, with Spanish speaking Registered Nurse (RN), Staff B revealed; she normally worked with Resident #1 three days a week from 7:00 AM to 7:00 FM. The resident was alert and oriented times three and communicated his needs well. Staff B, RN was asked about Resident #1 had, at times: I remember he did at some point take medications, and For about three days' Staff B, RN was not three days' Staff B, RN and son table to explain why the Medication Administration Records (MAR) indicated zero for, level the entire month of and Staff B insisted that the resident did not have the last times she cared for him (Thursday, to Saturday Staff B explained that on the day of the incident Resident #1 was on isolation precautions due to a	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
	{F 726}	opened and when he Resident #1 seate with a later that he pulled it and ran to get he well as \$11, staff resp. com where they tran backboard was place enforcement and EM thereafter and pronou. Residents body was I texaminer's office.  On speaking Registered revealed; she normall three days a week fresident was alert and communicated his ne asked about Residen acknowledged that Rimes; Il remember he medications, asked about three days" Ste explain why the Medi Records (MAR) indicentire month of insisted that the resid last times she cared for insisted that the resident was he cared for the staff of the staff was a last three days "Ste order to Saturd last three she cared for the staff was not sold as three staff was not sold as the staff was not sold from the sta	entered, the room he noted this wheelchair, ago over his The CNA he bag off Resident #1's elp. A code was called as onded to this resident's sferred him to the bed, a d, and initiated. Law Is responded shortly unced this Resident. The ransferred to the Medical strength of the manner of the m	₹F	726			

		ID HUMAN SERVICES MEDICAID SERVICES			FOR	M APPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		105910	B. WING _			R-C <b>/02/2021</b>
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CORAL RI	EEF SUBACUTE CARE O	CENTER LLC		9869 SW 152ND STREET MIAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
{F 726}	remember him having sometimes would gate asked that we closed or yell, don't touch me the patient's behavior was easily re-directed behavior monitoring s days that I worked. I and the What I documented when behavior of Resident #1 kept ask () treatme the episode w reason for the treatment of the worked that her documentatic monitoring sheets ab was related to the Resident #1 received was effective. Staff B in the nurses notes the repisode of , be not see him to be desenting the relationship to be desenting the property of the	g any behavior. He a little upset with the CNAs, the door, close the window, al Generally, I document if is constant. Normally, he is constant. Normally, he is I did complete the heet for the resident on the filled it out on day that he , was that he had one Staff B, RN explained that ing about the mt. The intervention, during as teaching about the ent, what was the reason, I in isolation. Staff B stated on on the behavior	(F 72	26)		
	follow for a prescriber and document the ep behavior, for which the medication. The internurses' notes. Staff B record to explain anytar or behavior. Stephavior. Stephavior stablished that a pat small episodes of	d medication, isodes related to the er esident is taking the vention was to refer to agreed there was no thing about the resident's				

the nurses' notes. The purpose of the behavior monitoring sheet is to see if the medication seems effective throughout the month ...what the

		ID HUMAN SERVICES MEDICAID SERVICES					M APPROVED O. 0938-0391
TATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD	iNG	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED R-C	
		105910	B. WING	_		11	/02/2021
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
CODAL D	EEF SUBACUTE CARE O	CENTEDILO			9869 SW 152ND STREET		
CORAL K	EEF SUBACUTE CARE C	SENTER ELC			MIAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDERICENCY)	BE	(X5) COMPLETION DATE
(F 726)	behavior monitoring s medication is effective, on episode could have b want to shower, I don B then agreed that the reflect the exact natus she did not know and behavior. Staff B state behavior. Staff B state behavior on 17th, 24th, 25th, 26th behavior, 1did not regithat I needed to compsychiatrist. We did not regithat I needed to compsychiatrist. We did not eight a diagnosis of she would have react in a person cause them to have a seemed well, he did not reject care or com discussion of Resider reported: "I am surprof, when remained in his bed approximately 7:10 P asked we close the dinvestigative report a Regional Nurse on	theet shows is that the  a. I documented that he had . 3rd, and 4th. The one een something like, "I don't if know the behavior." Staff e documentation does not re, or details of the behavior, could not recall the ed: I also documented no . 10th, 11th, 16th, . When I noticed the ort to anyone. I did not think municate it to the tot monitor him for know he had any gnoses of . With . "Staff B explained that ed differently and that rery dangerous, levels of 's can change and torisis." On that day he not seem depressed. He did ploplan of . "Upon In #1's diagnoses, Staff B issed that he had diagnossi I left on that day he I went in to see him at M he was in his room, he oor." (Note: The not in his room, he oor." (Note: The not in his room, he oor." (Note: The not have a staff to the proximately per surveillance video, Staff In his room at	₹F:	7726	3		
	On at 10:	SS AM the Development					

reported he did not review the above-mentioned behavior monitoring sheets in Resident #1's

PRINTED: 11/30/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND REAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED. A. BUILDING R-C 105910 R MING 11/02/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9869 SW 152ND STREET CORAL REEF SUBACUTE CARE CENTER LLC MIAMI, FL 33157 SUMMARY STATEMENT OF DEFICIENCIES. PROVIDER'S PLAN OF CORRECTION COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOURD RE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY (F 726) Continued From page 86 (F 726) clinical record. He explained that he met with facility staff and discussed residents' behavior and if any adjustments needed. When asked, the Psychiatrist reported he was not aware that Resident # 1 had any behaviors. Upon discussion of multiple documented episodes of afraid/panic noted on Resident #1's clinical record, the Psychiatrist reported he was not aware; the nurses did not communicate the behaviors to him, and the facility's staff should have \_\_\_, afraid/panic episodes and communicated . any other behavior exhibited by Resident#1. The psychiatrist stated: "If they told me I would definitely do something. The nurses usually call me. They did not tell me about those episodes. Had I known, I would have definitely done something, would have gone to see him, maybe change the medication." (F 867) (F 867) QAPI/QAA Improvement Activities SS=D CFR(s): 483.75(q)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(q)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies: This REQUIREMENT is not met as evidenced Based on records reviewed and interviews the facility failed to demonstrate an effective plans of The facility Developed a new QAPI plan action was implemented to correct identified and the facility QAPI Committee will quality deficiencies in problem-prope areas. monitor the following: related to . . . . , accuracy of assessments, and Neglect. informed development and implementation of care plan, care and behavioral health with emphasis

quality of care, accidents hazards/supervision and

quality assurance and performance improvement

(QAPI) as evidenced by repeated deficient

on monitoring residents prescribed

and

medications and identifying possible risk

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/30/2021 FORM APPROVED

DELLINATION	WEITT OF THE TETT	ID TIONING OLIVITOLO			FORM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		105910	B. WING _		R-C 11/02/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI	
			- 1	9869 SW 152ND STREET	
CORAL R	EEF SUBACUTE CARE (	CENTER LLC		MIAMI, FL 33157	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION
{F 867}	practice found in thes	e 87 se areas during consecutive rence F600, F641, F656,	{F 8€	factors and changes in	
	F684, F689, F867).	101100 1 000, 1 077, 1 000,		MDS accuracy of coding resid	
	The findings included	l: facility's survey history		Developing and following the regarding residents who are p	prescribed
	revealed, during the a	annual survey exit dated g this complaint survey with		medication to effectively moni effectiveness and side effects	tor for the
	the exit date practice was cited rel /Neglect (F600	repeated deficient ated to: Free from ). Accuracy of Assessments		medication  Developing and implementing care for diagnosis of	
		elop and implement a plan (F656), Accidents,		. and managemen management with develop	t
		, Devices related to facility		of care, and monitoring the re	
		the resident environment		for effectiveness	
	remains as free of ac			Identifying other areas of qual	
		sident receives adequate		through the quality improvement	
	accidents (F689) and	stive devices to prevent		review process as described i plan to: Identify and monitor t	
		rance and Performance		performance, Establish goals	
	Improvement (QAPI)			thresholds for the facilities per	
				measurement, Utilize resident	t, staff, and
		rsing Home Administrator		family input, Identify and prior	
				problems and opportunities fo	
	NHA reported the fac			improvement, Systematically	
		urance (QAA) program that nonth; on the third Thursday		underlying causes of systemic and adverse events and Deve	
		participants included the		corrective action or performan	
		OON), the Medical Director,		improvement activities.	ice
	the Assistant Director			provement dearnes.	
		ticipates, and Registered			
		sors. Participants included			
		including the Maintenance			
	Director and the House	sekeeping Director. Since		Residents with a diagnosis of	
		y, the committee continued		have the potential	to be
	to meet once a month	and the DON was the		affected.	

of the QAPI committee.

Residents that are prescribed . . . . , , and/or , .

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/30/2021

DEPARTMENT OF HEALTH A				FORM APPROVED
CENTERS FOR MEDICARE		-		OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES IND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105910	B. WING		R-C 11/02/2021
NAME OF PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	
CORAL REEF SUBACUTE CARE	OFWEED LLO		9869 SW 152ND STREET	
CORAL REEF SUBACUTE CARE	CENTER LLC	1	MIAMI, FL 33157	
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
OAP! plan that met NHA explained, "Wi to identify systemic in the committee bri been identified with Services Director for issue he addressed Then discuss a pos Nursing (DON) door brought to the meet from the last meetir intervention was put he start of the next we had a QAPI mer NHA described the quality deficiency re and with communic agencies. (Referre that AHCA (Agency Administration) cite and subsequent con surveys). The NHA repeated deficient p of staff lack of adher procedures, therefore deucation." The NHA reposted of staff lack of adher procedures, therefore deucation." The NHA reposted of staff lack of adher procedures, therefore deucation." The NHA repeated of section."	I, the NHA did not present a regulatory requirements. The shave a system that we use issues in our facility, everyone insu up and in the present that it is such that as in their department, the Social rexample, will express if any might require more attention, sible plan, the Director of uments everything that is ing. She types up the report greport and whatever tinto place are discussed at QAPI meeting. The last time sting was on The committee had identified lated to COVID -19 attor. If the committee had identified alted to COVID -19 or the committee had identified dated to COVID -19 or the committee had identified dated to COVID -19 attor. If the committee had identified dated to COVID -19 attor. If the committee had identified dated to COVID -19 attor. If the committee had identified alted to COVID -19 attor. If the committee had identified alter of the covid in the committee had identified dated to COVID -19 attor. If the committee had identified alter of the committee had identified alter of the covid in the committee had identified alter of the committee had identified alter of the covid in the committee had identified alter of the covid in the co	(F 867	medications have the potential to affected.  Residents who experience he potential to be affected.  Residents that have an MDS and the coding of their active diagnosis the potential to be affected.  The facility has conducted an aud following: Residents with a diagnosis of who are prescribed and me to ensure they have an effective p care in conjunction with implemen policies and procedures to identify	require shave to the control of the

care plan has been developed to monitor

DEPART	MENT OF HEALTH AN	D HUMAN SERVICES				FORM	APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES					0. 0938-0391
	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION		LETED
		105910	B. WING				-C 02/2021
NAME OF P	ROVIDER OR SUPPLIER			S'	TREET ADDRESS, CITY, STATE, ZIP CODE	,	
CORAL R	EEF SUBACUTE CARE O	PENTERLIC		98	869 SW 152ND STREET		
OOTALI	EEF GOUNGOTE ONICE	ETTER CEO		М	IAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
(F 867)	Continued From page	9 89	{F 2	867)	for effectiveness and side effects of the medication.  Residents that have a diagnosis of and were audited to ensure a care plan has been developed for behaviors related to their diagnosis and were audited to ensure behaviors related to their diagnosis and were audited to identify behaviors, interventions placed intervene with the behavior sand referred and the control of the c	o d d d d d d d d d d d d d d d d d d d	

Administrator and adopted with no

## PRINTED: 11/30/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES

DEPARTMENT OF HEALTH AN	D HUMAN SERVICES		FORM APPROVED				
CENTERS FOR MEDICARE & I	E & MEDICAID SERVICES OMB NO. 0938-						
ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED				
			R-C				
	105910	B. WING	11/02/2021				

ST ΔÞ STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 9869 SW 152ND STREET CORAL REEF SUBACUTE CARE CENTER LLC MIAMI, FL 33157 SUMMARY STATEMENT OF DEFICIENCIES. PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (F 867) Continued From page 90 {F 867} -Quality Assurance and Performance Improvement (QAPI) Program-Analysis and Action - Quality Assurance and Performance Improvement (QAPI) Program-Design and Scope -Quality Assurance and Performance Improvement (QAPI) Program-Feedback, Data, and Monitoring -Quality Assurance and Performance Improvement (QAPI) Program -Governance and Leadership -Quality Assurance and Performance Improvement Program (QAPI) Program Resident ...., Neglect and . Policy, Informed Care, Behavioral Health Services, .... Medication, - Clinical Protocol, Care Plans, Comprehensive Person-Centered. Certifying Accuracy of the Resident Assessment, . -Clinical Protocol, Accident & Incident-Investigation and Reporting The Consultant educated the Administrator regarding the above policies and the facilities QAPI plan. Administrator/designee educated facility staff on a one-to-one basis including Licensed Nursing Staff, and Social Services regarding behavioral health with emphasis on monitoring residents prescribed . . . . and

medications and identifying possible risk factors and changes in

... and

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 11/30/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEF AND PLAN OF CORF		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE	SURVEY
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NAME OF PROVID	ER OR SUPPLIER	103310	D: 11110		TREET ADDRESS, CITY, STATE, ZIP CODE	111/	02/2021
TOURS OF THOUSE	EN ON OUT DEN			1	869 SW 152ND STREET		
CORAL REEF S	SUBACUTE CARE	CENTER LLC		M	IIAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
(F 867) Con	tinued From page	991	(F: 8	867}	behavior as well as side effects and efficacy of medication Administrator/designee educated all st on a one-to-one basis regarding and Neglect. Nurse consultant education administrative staff on a one-to-one baregarding, neglect. informed care and behavioral health. The Administrator/designee educated Licensed Nurses on Developing and following the care plan regarding residit who are prescribed and predictions and medication and predictions and medication and prediction of the staff regarding developing and implementing plan of care for diagnosis of and The Administrator/designee educated Licensed Nurses, Certified Nursing Ald and Social Services regarding behavio health with emphasis on effectively monitoring residents with a diagnosis and to ensure referrals are made for mental health evaluations. Social services and nursing staff were educated by Administrator/designee or informed care including a new added questionnaire regarding. Social Services/designee completed informed screening on all curre residents.	ed siss	

		ID HUMAN SERVICES					APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION		LETED
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NAME OF PE	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		OLI LULI
			- 1	98	69 SW 152ND STREET		
CORAL RI	EEF SUBACUTE CARE O	CENTER LLC		M	IAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	Κ.	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
(F 867)	Continued From page	992	(F 8	67)	following the care plan for Residents whave to manage the Residents, and monitor the effectiveness and side effects of the medication. The Administrator/designee educated Licenseo Nurses and Certified Nursing Aides regarding , assessment, documentation and monitoring for, relief after interventions are placed. MDS consultant educated MDS staff regarding developing and implementing plan of care for , The MDS Consultant educated the MD staff on accurately coding the resident. The MDS consultant educated the MD staff on accurately coding the resident. WDS coding for accuracy during the resident's care plan review. MDS coding for accuracy during the resident's care plan review. Newly hired staff will be educated durin orientation by the DON/designee on monitoring residents with diagnosis of and and no monitor behaviors related to and and no monitor behaviors related to and and no monitor behaviors related to and and monitor behaviors related to and medication as well as informed care. Newly hired staff will be educated by the DON/designee during orientation on residents who are prescribed and medication to monitor for the effectiveness and side effects of the medication.	gaa S s s hee	

relief after interventions are placed. Newly hired staff will be educated during

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		MEDICAID SERVICES	-		OMB NO. 0938-	0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		105910	B. WING		R-C 11/02/2021	ŀ
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
		TENTED I I O		9869 SW 152ND STREET		
CURAL R	EEF SUBACUTE CARE O	SENTER ELC		MIAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLE	MOITE
(F 867)	Continued From page	993	₹F-867	orientation on behavioral health wit emphasis on monitoring residents vand of diagnosis a ensure referrals are made for ment health evaluations.  During the clinical meeting any cha noted in resident's and behavioral meeting and the effectiveness of the resident's or medical mental health referral. New admissions with a diagnosis or and thet are prescribed an or, medication will be reviewed clinical meeting to ensure a comprehensive plan of care will be developed and the medications will monitored for effectiveness and sidefects Residents who experience will reviewed in the clinical meeting to effective management. New admissions will be reviewed in clinical meeting to ensure a fefficity management. New admissions will be reviewed in clinical meeting for informe assessment and behavioral Monito sheet as indicated per diagnosis of and and referra behavioral health will be initiated an needed	with and to all all all all all all all all all al	

QAPI plan

minute's structure.

The facility will utilize their revised QAPI

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CENTERS FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-039
STATEMENT OF DEFICIENCIES IND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS CITY STATE ZIP CODE	

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		105910	B. WING			11/02	2021
	ROVIDER OR SUPPLIER EEF SUBACUTE CARE O	PENTER LLC	•	98	REET ADDRESS, CITY, STATE, ZIP CODE 69 SW 152ND STREET IAMI, FL 33157		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
{F 867}	Continued From page	94	{F 8	67}			
					The following will be audited: The Administrator/designee will audit current residents with a diagnosis of and weekly x4 and monthly x3 to ensure behavior sheets reflect the resident's behaviors, that tho	se	
					behaviors have interventions placed to intervene with the behavior, and the efficacy and any side effects of the		
					The MDS Nurse/designee will conduct a audit of residents MDS coding for active diagnosis with each submission for 3 months to ensure the Resident's MDS is coded accurately for active diagnosis	•	
					The DON/designee will audit current residents who are on and medication week! 4 and monthly x 3 to ensure care plans have been developed to monitor the effectiveness of the medications and monitor for side effects.	у×	
					The DON/designee will audit Residents Medication Administration Record week X4 then monthly X3 to ensure Resident management is effective.		
					The DON/designee will audit residents with a diagnosis of and weekly x4 and monthly x3 to ensure		

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DEPARTMENT OF REALTH AN	ID HUMAN SERVICES			FORM APPROVE	
CENTERS FOR MEDICARE & MEDICAID SERVICES					
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS CITY STATE ZIP CODE		

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		105910	B. WING	_		11/02/2021
IAME OF P	ROVIDER OR SUPPLIER			5	TREET ADDRESS, CITY, STATE, ZIP CODE	
				98	869 SW 152ND STREET	
ORAL R	EEF SUBACUTE CARE O	CENTER LLC		м	IAMI, FL 33157	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID.		PROVIDER'S PLAN OF CORRECTION	(305)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI	x	(EACH CORRECTIVE ACTION SHOULD BE	COMPLETIC
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIATE	DATE
					DEFICIENCY)	
(E 967)	Continued From page	. 05				
{L 001}	Continued From page	3 90	{F 8	867}		
					behavior monitoring sheets accurately	
					reflect resident's behaviors and referrals	
					are made for and mental	
					health evaluations as needed	
					Social Services/designee will audit newly	
					admitted residents weekly X4 and monthly	v
					X 3 to ensure they have been screened	<b>'</b>
					for informed care	
					The Administrator/designee will audit the	
					facilities QAPI plan x 3 months for the key	,
					elements of the program to assure that	
					they are occurring and that the program is	3
					efficient.	
					The Administrator/designee will review	
					results of the audits with the QAPI	
					Committee for review and feedback.	
					Responsible Party:	
					Administrator/Designee	
					Date of Compliance	