STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106021	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ponce Health and Rehabilitation Center	335 SW 12 Avenue Miami, FL 33130

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review the facility failed to ensure residents received an accurate Preadmission Screening and Resident Review (PASRR) Level I screening and a Level II screening for one (Resident 91) out of two residents reviewed. Resident 91 did not receive a PASSAR Level II after admission to the facility. There were a total of 139 residents residing in the facility at the time of this survey. The findings included: Record review of the Preadmission Screening and Resident Review (PASSR) Policy and Procedure (reviewed January 2025) documented: Policy-The facility ensures that a all residents admitted to the facility has PASSR Level I done prior to admission to facility or Level II as indicated by resident's condition and diagnosis of resident. Procedure: 1) Prior to admission, the admission department including nurse navigator must ensure that hospital or another nursing home facility has completed PASSR Level I for new residents prior to admittance to facility and 2) Upon receipt of PASSR I from hospital or another nursing home, facility will review PASSR Level by DON (Director of Nursing) or designee. If PASSR Level I indicates that a resident has serious mental illness and PASSR Level I indicates that a PASSR Level II is needed, facility must request from hospital or another nursing home, a PASSR Level II prior to admission to facility. Observation of Resident number 91 on 5/14/2025 at 7:52 AM revealed the resident sitting up in bed, eating breakfast with the television on. Review of the Demographic Face Sheet for Resident number 91 documented the resident was admitted on [DATE] with a diagnosis of acute respiratory failure, bipolar disorder, major depressive disorder, insomnia, dementia and schizophrenia. Review of the Minimum Data Set (MDS) Annual Assessment for Resident number 91 dated 2/27/2025 documented the resident's Mental Status (BIMS) Summary Score was not scored indicating severe cognitive impairment, the resident required substantial/maximal to dependent assistance for ADLs (Activities Daily Living) and Preadmission Screening and Resident Review (PASRR), the resident was not evaluated for a Level II PASSR and was not considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. The resident was not evaluated for PASRR Level II. (continued on next page)

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

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Physician's Order Sheet (POS) for March 2025, April 2025 and May 2025 documented the resident received Mirtazapine Tablet 7.5 MG (milligrams) give 1 tablet by mouth at bedtime related to major depressive disorder and Sertraline HCl (Hydrochloride) Oral Tablet 25 MG give 1 tablet by mouth in the morning related to major depressive disorder. Review of the Care Plans for Resident number 91, written 7/07/2022 documented the resident did not receive psychotropic medications. Review of the PASRR for Resident number 91 documented the PASRR Level I was completed on 1/30/2024, the diagnoses bipolar disorder and depressive order were checked off. The diagnosis of schizophrenia was not checked off and a Level II was not completed. Interview with the Director of Nursing (DON) on 5/15/2025 at 6:47 AM. He stated, Yes, I am the one who completes and checks the PASSR Level I. The PASRR Level I was completed on 1/30/2024. She has diagnoses of bipolar disorder, depressive disorder and schizophrenia. The diagnosis of schizophrenia was not added to the Level I and should have been added. That is the reason the Level II was not done.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on observations, interview and record review, the facility's quality assurance and assessment committee failed to demonstrate an effective plan of action was implemented to correct an identified quality deficiency in the problem area related to repeated deficient practice for F645- PASARR Screening for Mental Disease (MD) and Intellectual Disability (ID). As evidenced by: F645 was cited during a Recertification survey ending 12/21/23 when the facility failed to ensure a level 1 Preadmission Screening and Resident Review (PASRR) was completed accurately prior to admission and failed to revise the screening following admission for four (4) Residents This repeated deficient practice has the potential to affect any of the 139 residents residing in the facility at the time of the survey. The findings included: Record review of the facility's survey history revealed, during a recertification conducted on December 18, 2023, through December 21, 2023, at the facility. F645-PASRR Screening for Mental Disease (MD) and Intellectual Disability (ID) was cited as the facility failed to ensure a level 1 Preadmission Screening and Resident Review (PASARR) was completed accurately prior to admission and failed to revise the screening following admission for four (4) Residents. Review of the facility policy and procedure titled Quality Assurance and Performance Improvement revision date 01/01/25 states: It is the policy of this facility to develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The QAPI plan will address the following elements: a. Design and scope of the facility's QAPI program and QAA Committee responsibilities and actions. b. Policies and procedures for feedback, data collection systems, and monitoring. c. Process addressing how the committee will conduct activities necessary to identify and correct quality deficiencies. Key components of this process include, but are not limited to, the following: Tracking and measuring performance; Establishing goals and thresholds for performance improvements; Identifying and prioritizing quality deficiencies; Systematically analyzing underlying corrective action or performance improvement activities. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Monitoring and evaluating the effectiveness of corrective action/performance improvement activities and revising as needed. d. A prioritization of program activities that focus on high-risk, high-volume, or problem-prone areas as identified in the facility assessment that reflects the specific units, programs, departments and unique population the facility serves. e. A commitment to quality assessment and performance improvement by the governing body and/or executive leaders. f. Process to ensure care and services delivered meet accepted standards of quality. Review of the Quality Assurance and Performance Improvement (QAPI) Committee Meeting Sign-in Sheets dated 02/27/2025, 03/27/2025, and 04/24/25 documented the facility had QAA Committee meetings monthly. Attendees included: Administrator, Medical Director, Director of Nursing (DON), Infection Control Preventionist, Risk Manager, Dietary Manager, Clinical Dietician, Director of Housekeeping, Director of Maintenance, Director of therapy, Director of Human resources, Director of admissions, Director of Business office, Director of Social Services, Director of Activities, MDS (Minimum Data Set) Coordinator. Interview on 05/15/2025 at 12:07 PM with the Administrator (NHA) stated the QAA Committee meets every month, the last meeting was held on 04/24/2025. The committee consists of the Medical Director, Administrator, Director of Nursing (DON), Infection Preventionist and all interdisciplinary team members. The purpose of QAPI is to make improvements on the quality of care we provide. Identify issues or potential issues and determine what we can do to prevent these issues from occurring.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews, the facility failed to follow infection prevention and control procedures for Residents (#13, #106, #129, #234). As evidenced by Residents # #13, # 106, #129, and #234 Incentive Spirometer were observed stored at bedside with no protective covering. There were 139 residents residing in the facility at the time of the survey. The findings included: Resident #13 During an observation on 05/12/25 at 06:51 AM Resident #13 was in bed asleep, an Incentive Spirometer was on the bedside table with no protective covering (Photo Evidence) On 05/13/25 at 08:21 AM Resident # 13 was observed in bed awake, eating breakfast, an Incentive Spirometer was being stored on bedside table with no protective covering. On 05/14/25 at 11:20 AM Resident # 13 was sitting on side of bed, receiving therapy provided by rehab staff, no distress noted, the Incentive Spirometer not in the room. Review of the medical records for Resident # 13 revealed the resident was admitted to the facility on [DATE]. Clinical diagnoses included but not limited to: Chronic Respiratory Failure with hypoxia. Resident #106 During observation on 05/12/25 at 06:55 AM Resident #106 was in bed asleep, Incentive Spirometer at bedside stored with no protective covering (photo evidence). Observation on 05/13/25 at 08:20 AM Resident #106 was in the room, family visiting, Incentive Spirometer being stored at bedside with no protective covering. On 05/14/25 at 10:01 AM Resident #106 was observed in room in wheelchair, family at side,the Incentive Spirometer was stored at bedside with no protective covering. Review of the medical records for Resident # 106 revealed the resident was admitted to the facility on [DATE]. Clinical diagnoses included but not limited to: Type II Diabetes Mellitus with Hyperglycemia. Resident #129 During observation on 05/12/25 at 06:58 AM Resident #129 was in bed asleep,there was an Incentive Spirometer on the bedside table with no protective covering (photo evidence). On 05/13/25 at 08:11 AM Resident #129 was in bed eating breakfast, the Incentive Spirometer stored at the bedside had no protective covering (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/14/25 at 09:56 AM Resident #129 was in room receiving care from staff, the incentive Spirometer stored at bedside had no protective covering. Review of the medical records for Resident #129 revealed the resident was admitted to the facility on [DATE]. Clinical diagnoses included but not limited to: Traumatic Subdural Hemorrhage with loss of consciousness. Resident #234 During observation on 05/12/25 at 06:57 AM Resident #234 in bed asleep in bed, Incentive Spirometer on bedside stored with no protective covering (photo evidence). On 05/13/25 at 08:10 AM Resident # 234 in bed eating breakfast, Incentive Spirometer not at bedside. Review of the medical records for Resident # 234 revealed the resident was admitted to the facility on [DATE]. Clinical diagnoses included but not limited to: Rhabdomyolysis Interview on 05/14/25 at 09:29 Licensed Practical Nurse (Staff A), 4th floor unit revealed, for the residents that have Incentive Spirometers, when they are not being used, they are stored in a clear bag with the date, the bag is changed weekly, and the Spirometer is cleaned after each use. On 05/14/25 at 09:43 AM Licensed Practical Nurse (Staff B), reported (via Spanish/English translator) for the residents that have Incentive Spirometers, when they are not being used they are stored in a clear bag, the equipment is cleaned after each use and the bags are changed weekly, the reason for cleaning the Spirometer and storing in the bag is for infection control prevention. On 05/14/25 at 10:27 AM Assistant Director of Nursing (ADON) revealed the residents with Incentive Spirometer use them for 15 minutes two times a day, after use they are cleaned and placed in a clear plastic bag, the bag is replaced weekly and dated, so the nursing staff know when to replace the bags. This is done daily for infection control purposes, we do the same procedure for oxygen tubing and nebulizer masks. On 05/15/25 at 08:48 AM Director of Nursing (DON) revealed the three residents observed with Incentive Spirometers in their rooms, no longer have orders for the use of the Incentive Spirometers, those residents choose to keep the Incentive Spirometers, as a result the Incentive Spirometers are now considered personal property of those residents and do not need to be stored in protective covering. In addition. Review of the facility policy and procedure titled Infection Prevention and Control and Surveillance Program revision date 01/2025 states: It is the policy of the facility to ensure that the Infection Control Program is designed to prevent, identify, report, investigate, and control the spread of infections and communicable disease for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement; provide a safe, sanitary and comfortable environment; and to help prevent the development and transmission of disease and infection, in accordance with State and Federal Regulations, and national guidelines. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy and procedure titled Incentive Spirometers dated 01/2025 states all residents who use an Incentive Spirometer must have a dedicated device. Incentive Spirometers must be cleaned routinely according to this policy to prevent respiratory infections and ensure device functionality. Weekly cleaning instructions by 11-7 nursing staff: #7. Store the device in a clean, dry area within the resident's room.