STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106132	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Dade Nursing and Rehabilitation Center	17475 S Dixie Hwy Miami, FL 33157

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 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility had failed to obtain admission orders for a medicated patch for one (Resident #175) out of three sampled newly admitted residents. Resident #175 had an undated medicated patch that the resident reported was for hypertension on the left shoulder but there was no corresponding physician's order in the resident's clinical records, which noted orders for oral hypertensive medications that the resident had been receiving since admission. This deficient practice could have caused severe hypotensive reactions for Resident #175, who had been admitted from the hospital to the facility six days earlier. At the time of the survey, 166 residents resided in the facility.Observation on 12/09/25 at 11:20 AM revealed an undated patch on Resident # 175's left shoulder. (photo evidence) Upon interview, Resident#175 stated: This patch is for hypertension and is to be changed monthly. I received it from the hospital, and I told staff, but no one has done anything. The surveyor notified Staff C, Registered Nurse (RN) who stated, I don't know about a patch and I will check.Observation and interview on 12/09/25 at 11:20 AM revealed an undated patch on Resident #175's left shoulder. (photo evidence) Resident #175 revealed: This patch is for hypertension and is to be changed monthly. I received it from the hospital, and I told staff, but no one has done anything. The surveyor then notified Staff C, a Registered Nurse (RN), who replied, I don't know about a patch and I will check. On 12/9/25 at 12:07 PM, the 3rd floor RN Supervisor approached the surveyor and stated, No one knows what type of patch it is. [Resident#175] came from the hospital and does not want to remove it. I spoke to the doctor today and the doctor will come to see the resident and possibly gives new orders. Surveyor asked, Are skin checks done upon admission? The RN, Supervisor replied: Yes but that was missed.On 12/9/25 at 2:56 PM, the Director of Nursing approached the surveyor and revealed they had received new orders for a medicated patch for hypertension for Resident#175.The demographic sheet review revealed that Resident#175 was admitted on [DATE] with diagnoses including Essential (PRIMARY) Hypertension (HTN). Record review revealed all Minimum Data Sets were in progress.Record review of a December 2025 physician's order sheet revealed an order dated 12/3/25 for Metoprolol Succinate Oral Capsule Extended Release 24 Hour Sprinkle 50 Milligrams (MG) by mouth one time a day for HTN.Record review of a care plan initiated on 12/04/25 and Revision on 12/05/25 revealed Resident #175 was at risk for cardiac/circulatory complications related to: Hyperlipidemia, HTN, Coronary Artery Disease and Congestive Heart Failure with interventions that included: Give medications as ordered, monitor for adverse signs, and symptoms.Record review of the facility's policy titled Physician Services dated 3/1/21 revealed Intent: It is the policy of the facility to ensure Physician Services are in accordance to State and Federal regulations.

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.

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to provide an environment free of accident hazards for one (Resident#156) out of one sampled resident as evidenced by an observation of Resident #156 in bed unattended while the bed was in a high position. There were 166 residents residing in the facility at the time of survey. The findings included:On 12/09/25 at 10:20 AM, the surveyor observed Resident #156 lying in bed with legs extended over the edge of the bed. The bed was in a high position. (photo evidence) A call light was in reach; however, Resident#156's arms appeared to be contracted. No staff were present. The surveyor immediately notified Staff E, Certified Nursing Assistant (CNA), about the identified concern. Staff E, CNA, immediately lowered the bed. The surveyor interviewed Staff E, CNA, about the facility's protocol for supervising residents to prevent falls. Staff E stated, If no staff is present, the bed should be low and the head of bed up so the resident doesn't fall. This resident cannot walk but can move the legs. I left it up because I was getting another staff member to help me take the resident out of the bed. Staff C, Registered Nurse (RN), was present for the interview.Record review of a demographic sheet revealed Resident#156 was admitted on [DATE] with diagnosis that included: Intracranial injury with loss of Consciousness.Record review of a Quarterly Minimum Data Set reference dated 9/30/25 revealed Resident#156 had a Brief Interview of Mental Status score of 11 indicating moderate cognitive impairment, required substantial/maximal assistance for transfers, and no falls since admission/entry or reentry or the prior assessment.Record review of a care plan initiated on 12/29/22 and revised on 9/23/25 revealed Resident #156 was at risk for falls related to impaired mobility, Hemiplegia-Muscle weakness, Anxiety and Reduced mobility with interventions that included: Keep bed in lowest position.On 12/09/25 at 11:11 AM The Director of Nursing and Assistant Director of Nursing were made aware of the identified concerns and stated, Staff are responsible for monitoring residents to ensure safety. Record review of Facility's policy titled Falling Star issued on 10/1/2021, 8/2023 revealed Policy: The residents will receive adequate supervision, assistance and assistive devices to aid in the prevention of falls. Each resident will be evaluated for safety risks including falls and accidents. Care plans will be created and implemented based on the individual's risk factors to aid in the prevention of falls.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on record reviews observations and interviews, the facility stored drugs and biologicals contrary to professional standards. Specifically, one out of three medication rooms had expired medical supplies; two out of six medication carts had loose pills, and medications were found at the bedsides of two out of 166 residents who resided in the facility during the survey. The findings included: Record review of facility policy titled Labeling of Medications Storage of Drugs and Biologicals implemented on 11/28/2019, reviewed and revised on 8/2023 revealed Policy: It is the policy of this facility to ensure that all medications and biologicals used in the facility will be labeled and stored in accordance with current state, federal regulations. Resident #45 On 12/08/25 at 10:57 AM Resident #45 was observed in bed with eyes closed in no apparent distress. A bottle of medicated shampoo was observed at bedside. (photo evidence) On 12/08/25 at 11:07 AM Staff C, Registered Nurse (RN) was notified about the identified concern and removed the bottle. Staff C, RN was interviewed about the facility's protocol for medication storage and stated, There should be no medications at the bedside. This shampoo is kept in the wound cart. I do frequent rounds to make sure no medications are in the room. During a follow up observation on 12/09/25 at 10:31 AM Resident #45 was observed lying in bed with eyes closed, no apparent distress and two packets of Vitamin C were observed on Resident's nightstand. (photo evidence) On 12/09/25 at 10:51 AM Staff C, RN, was notified about the identified concern and removed the packets. On 12/09/25 at 10:54 AM Staff D, Certified Nursing Assistant (assigned CNA) stated, I check residents throughout the shift. I did not see any medications at the bedside. I know no medications should be at the bedside. On 12/09/25 at 11:09 AM, the Director of Nursing approached surveyor in the dining room and stated, In reference to the Vitamin C packets, they were brought in and left in the room by a visitor. The visitor was educated. Staff are expected to do rounds and remove any medications from bedside. 2nd Floor East Medication Cart. On 12/09/2025 at 11:26 AM, during inspection of the 2nd Floor East Medication Cart alongside Staff B, Licensed Practical Nurse (LPN), a loose pill was found in the cart; Staff B, LPN revealed loose pills are not supposed to be inside the cart. Resident # 94 (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/08/2025 at 12:09 PM, an over-the-counter cough medication was observed on Resident # 94's bed. The resident stated, That's mine, don't touch. (Photographic evidence) Observation on 12/09/2025 at 09:45 AM in Resident # 94's room, an aerosol treatment was in use, medication was observed on the table tray beside the bed. The resident asked surveyor what was being looked at stating the items belonged to her and that she had brought them in previously. (Photographic evidence) On 12/10/2025 at 12:51 PM, Resident # 94 was observed lying in bed in an upright/sitting position with the television on. Cough medicine was observed on the resident's bedside table tray. On 12/11/2025 at 7:48 AM, Resident # 94 was watching television; cough medication was observed on the resident's bed along with other personal items within her reach. (Photographic evidence) Interview on 12/11/2025 at 08:37 AM, the Director of Social Services revealed all medications must be stored and managed by nursing staff. An interview conducted on 12/11/2025 at 08:50 am revealed Staff F, Registered Nurse (RN), had not seen the cough medication in Resident # 94's room that day. She reported observing the resident with medications and other personal items in her room in the past. Staff attempted to educate the resident, explaining that facility policy prohibited keeping medications in her room. 4th Floor Medication Room On 12/09/2025 at 10:04 AM, during an inspection of the 4th Floor Medication Room alongside Staff A, License Practical Nurse (LPN), expired medical supplies were found that included: Ten (10) Eternal Distal End Transition Connector with cap (expired 11-28-2025), one (1) Intravenous (IV) start kit (expired 04-30-2025) and two (2) Suction Yankers (expired 03-28-2025). 4th Floor East Medication Cart On12/09/2025 at 10:31 AM inspection of the 4th Floor East Medication Cart alongside Staff A, LPN, a loose pill was found in the cart. Interview on 12/11/2025 at 01:06 PM, the Director of Nursing (DON) stated: There should never be any expired medications or supplies in the medication rooms. Central Supply is responsible for stocking the rooms and checking for expired items to replace them. Nurses are expected to check expiration dates before each med pass and properly dispose of anything expired or call the pharmacy as needed. Expired medications are placed in the drug buster. Nurses are expected to check expiration dates before each med pass and properly dispose of anything expired or call the pharmacy as needed. Expired medications are placed in the drug buster, and the same applies to any loose pills; there should be no loose pills in the carts, and nurses are required to check for them daily and dispose of them appropriately. The 11:00 PM to 7:00 AM shift nurses are responsible for checking the carts each night, including insulin and any other items that may be expired. Class III