STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105083	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broward Nursing & Rehabilitation Center	1330 S Andrews Ave Fort Lauderdale, FL 33316

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40153 Based on observations, interviews, and record review, the facility failed to identify significant weight loss and provide nutritional interventions in a timely manner for 2 of 6 residents reviewed for nutrition (Resident #12 and Resident #13). The findings included: A review of the facility's policy titled Weight Assessment/Evaluation and Intervention, revised on 11/2021, revealed that Weights will be recorded in the individual's medical record. Any weight change of 5% or more since the last available weight will be retaken for confirmation. If the weight is verified, the nurse will notify the Dietitian. The threshold for significant unplanned and undesired weight loss/gain will be based on the following criteria: One month, 5% of weight loss is significant, and greater than 5% is severe. 3 months-7.5% weight loss is significant, and greater than 7.5% is severe. 6 months- 10% weight loss is significant, and greater than 10% is severe. 1.) A record review showed that Resident #12 was readmitted on [DATE] with diagnoses of Heart Disease, Hemiplegia, and Spinal Stenosis. The Significant Change Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status score of 15, which indicated the resident is cognitively intact. A review of the weight log for Resident #12 showed the following: On admitted d 11/8/24, a weight of 189.2 pounds was recorded. On 11/20/24, a weight of 177.8 pounds was recorded. On 11/26/24, a weight of 175.4 pounds was recorded. On 01/23/25, a weight of 160.6 pounds was recorded. (continued on next page)

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The above weights showed a severe 6% weight loss from 11/8/24 to 11/20/24, a severe weight loss of 7.3% from 11/8/24 to 11/26/24, and a 15.1% severe weight loss from 11/8/24 to 01/23/25. In an interview conducted on 02/10/25 at 11:30 AM, Resident #12 stated that he came into the facility with a Pressure Ulcer, which gotten worse in the hospital. He has lost weight from around 175 pounds to 160 pounds and said that he did not like the meals provided at times but liked his breakfast meal every morning. His family brings food from home for lunch and dinner. He also receives Ensure (a nutritional supplement) twice daily and drinks them all. In an interview conducted on 02/11/25 at 3:00 PM with Resident #12, he stated that he did not eat his grilled cheese sandwich for lunch and asked for a ham and cheese sandwich. He said that he gets Ensure for breakfast and lunch. For breakfast, he only eats his cereal, orange juice, bacon, and coffee and does not like any eggs. He drinks one can of Ensure for breakfast for extra protein. The Initial Nutrition Evaluation dated 11/11/24 revealed the following: Resident #12's estimated caloric needs between 2580-3010 calories and 107.5-129 grams of protein a day. A stage 4 pressure ulcer was noted in the sacrum area, and unstable deep tissue injury to the left foot. In this note, it was recommended to provide Expedite (protein supplement) 60 milliliters (ml) daily to provide an extra 100 calories and 10 grams of protein. The subsequent follow-up nutritional note dated 11/29/24, which was 9 days after the 6% severe weight loss was identified, showed the following: Resident with Usual Body Weight history of 175 pounds to 201 pounds and intake of meals varies from 25% to 100% of meals. It was noted that Resident #12 was receiving Expedite 60 ml once daily, and Ensure once a day was recommended for nutritional support. Resident #12 was eating 50% of the average intake of his meals, which is likely not sufficient to meet increased energy needs. A follow-up nutritional note dated 12/31/24, which was completed by Staff A, Dietary Technician, revealed the following: Resident #12 triggered for significant weight loss and was eating 76% to 100% of his meals. It was again recommended to add Expedite 60ml to aid in wound healing. A Nutrition/Dietary note dated 01/23/25 indicated that Resident #12 lost 8.4% of body weight in about 2 months. Per medical record, Resident #12 was consuming an average of 1100 calories to 1650 calories a day (50%-75%). It was recommended to increase the Ensure supplement from 1 bottle a day to 2 bottles a day. A review of the Medication Administration Record revealed that Expedite was given from 11/14/24 until 12/12/24 and was never given after 12/12/24. The Care plan dated 10/14/24 showed that Resident #12 has the potential for weight loss related to slow healing and altered nutrition and hydration status. Monitor weight loss of over 5% in one month and 7.5% in 3 months. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview conducted on 02/11/25 at 2:18 PM with Staff A, Staff A stated that the Restorative team takes the weights on all residents, and then it is given to her to put into the electronic system. She prints weight loss reports for weekly or monthly weights and can track any significant weight loss. For significant/severe weight loss, she will try to intervene as soon as possible or no later than 48 hours. The weekly weights are done starting on Monday, and that list is given to her by Wednesday, and that is when she looks at them. Staff A reported that she was unsure if Resident #12 was eating well and that she needed to look at the nutritional notes regarding Resident #12. In an interview conducted on 02/13/25 at 9:07 AM with Staff E, the Unit Manager stated that she runs a report on residents who need their weekly and monthly weights taken. The report is then given to her staff, who take the weights and write them down on it. That report is then given to the Dietitian to place in the electronic system. 50370 2.) A record review revealed Resident # 13 was admitted on [DATE], with diagnoses that included Sacral Wounds, Local Infection of the Skin and Subcutaneous Tissues, Macular Degeneration and Dysphagia. A review of the Minimum Data Set (MDS) assessment Section C dated 01/10/25, revealed a Brief Interview for Mental Status (BIMS) score of 9 indicating fair cognition. Section M revealed 1 stage 3 pressure ulcer, 3 stage 4 pressure ulcers, and 3 stage 4 pressure ulcers present during admission. A review of Resident #13's weights recorded on the Electronic Health Record (EHR) revealed the following: On 02/07/25 158.2 pounds. On 01/13/25 163.0 pounds. On 12/11/24 162.0 pounds. On 11/14/24 167.8 pounds. On 10/03/24 170.0 pounds. A record review of the Medication Administration Record (MAR) dated 10/03/24 revealed to offer the resident an evening snack. Additional dietary supplements of Expedite Wound Supplement 60 ml one time a day for wound healing was ordered on 12/31/24. A No Salt Added (NSA) Liquid Protein 30 ml one time a day by mouth, was ordered on 01/14/25. A NSA House shake one time a day, for nutrition support to be given at lunch was ordered on 01/15/25. A review of nutrition progress notes dated 11/25/24 revealed non-significant weight loss may be acceptable at this time due to comorbities, with an added recommendation of Expedite 60 ml (milliliter) once a day, to promote wound healing. Additional record review revealed no nutrition progress notes were documented between 11/25/24 until survey on 02/12/25. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with Registered Dietary Technician, Staff A, on 02/12/25 at 11:45 AM, when asked why there was no dietary or nutrition intervention for the stage 4 wounds and weight loss after resident's readmission on 10/02/24, she stated she wrote a script for Expedite on 11/19/24, but she did not know why it was not documented in the MAR until 12/31/24. When asked how often she monitors this resident after weight loss, she stated, frequently. She stated she will find the paperwork to support the reason why the order was not written in MAR as soon as she wrote it. Until the last day of the survey, no written notes were given to the surveyor. In an interview with the Director of Nursing (DON) on 02/13/25 at 10:18 AM, when asked regarding Resident #13's weight loss and wounds, she stated, the resident's wounds are improving, and she only has 5 unhealed wounds. This resident has vascular issues, Dementia, Diabetes, and Peripheral Vascular Disease, where a recent doppler feet assessment revealed limited circulation. With all these underlying medical diagnoses, this resident is susceptible to weight loss. When asked how many times this resident was hospitalized , she responded Two times, on 06/20/24 and on 08/29/24. When asked if she had known about this resident's weight loss, she responded, Yes. When asked if Nurses provide dietary supplement as ordered, she responded Yes. The DON added that the resident was started on Protein supplement, Expedite and House supplement on 12/31/24. When asked why the supplements started late instead of when the weight loss was documented. She did not respond.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36057 Based on record review, observations, interviews and the facility's policy review, the facility failed to ensure 1 of 1 sampled resident reviewed for oxygen use, received oxygen therapy as per physician order (Resident #37). The findings included: Review of the facility's policy titled Oxygen Concentrator revised on August 2024 documented .oxygen should be administered only under orders of the attending physician . Review of Resident #37's clinical record documented an admission on 01/17/22 with a readmission on 02/13/23. The resident diagnoses included Essential Hypertension, Type 2 Diabetes Mellitus with Diabetic Neuropathy, Anemia, and End Stage Parkinson's Disease. Review of Resident #37's Minimum Data Set (MDS) quarterly assessment dated [DATE] documented a Brief Interview of the Mental Status (BIMS) score of 12 indicating that the resident had moderate cognition. The assessment, documented under Functional Abilities and Goals the resident was dependent on the staff to complete all activities of daily living (ADLs). The assessment documented the resident was using oxygen. Review of Resident #37's care plan titled [Resident} complaint of dry cough .08/12/24 no current s/s (signs/symptoms) .O2 (oxygen) in use . initiated on 07/20/22 and revised on 11/13/24. Care plan interventions included .oxygen settings; oxygen via nasal cannula continuously as ordered . Review of Resident #37's clinical record revealed a physician order dated 11/15/24 for Oxygen via nasal cannula at 2 L (liters) per minutes continuous every shift for SOB (shortness of breath), wheezing. Review of Resident #37's clinical record progress notes from 11/13/24 to 02/10/25 did not address the resident's use of the oxygen therapy or any issues related to the oxygen use. Review of Resident #37's February 2025 Medication Administration Record (MAR) documented Oxygen via nasal cannula at 2 L per minutes continuous every shift for SOB, wheezing. Further review revealed Staff F, Registered Nurse (RN) documented on the MAR she administered Resident #37's oxygen at 2 liters per minute on 02/10/25 and 02/11/25. On 02/10/25 at 10:25 AM, observation revealed Resident #37 in bed, alert and wearing an oxygen nasal cannula. An interview was conducted with the resident who stated he wore the oxygen at all times. Observation revealed the resident's oxygen tubing was connected to a humidifier bottle that was attached to an oxygen concentrator machine. Further observation revealed the concentrator machine was facing the wall and the oxygen flow meter rate was set at 4.5 liters per minute (Photographic evidence obtained). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/11/25 at 10:22 AM, observation revealed Resident #37 in bed, eyes closed, wearing an oxygen nasal cannula connected to a humidifier bottle that was attached to an oxygen concentrator machine. Further observation revealed the concentrator machine was facing the wall and the oxygen flow meter rate was set at 4.5 liters per minute (Photographic evidence obtained). On 02/11/25 at 2:01 PM, an interview was conducted with Staff F, RN who stated Resident #37 was on continuous oxygen at 2 liters and if any changes she will call Hospice. Consequently, a side by side observation of Resident #37's oxygen flow meter rate was conducted with Staff F, Staff H, Unit Manager Staff I, Certified Nursing Assistant. Staff I stated the nurses do change the resident's oxygen rate and added she will moves the oxygen concentrator when providing care. Staff F and Staff H confirmed Resident #37's oxygen flow rate was set at 4 liters per minute. Staff H stated the physician order was for oxygen at 2 liters per minute. Staff F stated she was not aware of any issue with the oxygen. Staff F was asked if she checked the oxygen rate and stated honestly I did not check the oxygen machine flow rate. On 02/12/25 at 11:45 AM, the surveyor was approached by the Director of Nursing (DON) who stated Resident #37 previously had an oxygen order range of 2-4 liters continuously and it was changed. The DON submitted a physician order created on 11/15/24 at 14:27 (2:27 PM) that documented Oxygen via nasal cannula at 2-4 liters continuously every shift, and it was discontinued on 11/15/24 at 14:46 (2:46 PM). The DON was apprised Resident #37 was not receiving his oxygen therapy as ordered by the physician during surveyor observations from 02/10/25 through 02/11/25. On 02/12/25 at 1:45 PM, observation revealed a Hospice nurse in Resident #37's room. An interview was conducted with the hospice nurse who stated she got a call today from the facility that the resident was desaturating (oxygen levels dropping) and added she checked the resident and he was fine on 2 liters of oxygen but obtained a physician order for 4 liters of oxygen as needed.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41837 Based on record review and interviews the facility failed to ensure a Registered Dietitian provided and documented oversight of assessments and recommendations performed by a Dietetic Technician, Registered (DTR) for 2 of 31 sampled residents (Residents #58 and #12). The findings included: Review of the Service Agreement - RDN/LDN/NDTR (Registered Dietitian Nutritionist/Licensed Dietitian Nutritionist/Nutrition and Dietetics Technician, Registered) dated 08/06/24 between the facility and contracted company included in part the following: Services: Contracted company will provide RDN/LDN/NDTR to facility for the execution of ongoing clinical nutrition management services using systems and processes directed by the facility. Contracted company will perform these services in accordance with currently accepted professional standards and all applicable federal, state and local lows and administrative regulations. Review of the Job Description for the Consultant Dietetic Technician (Provided by the contracted company) dated 06/20/22 included in part the following Job Responsibilities: 1. When indicated, completion of nutrition screens, evaluations, care plans, MDS as warranted and directed by the RDN/LDN. All nutrition services proved will comply with Federal and State Regulations, CMS guidelines, Joint Commission and contracted company standards as applicable. All nutrition services provided will be under the supervision of RDN/LDN. 2. Identification of clients with nutritional risk factors and development of an individualized plan of care for each client to address identified risk factors. 3. Recommendations for interventions will be made in accordance with the protocols for specific conditions or disease states as set forth by contracting company and facility policy using the Consultant Dietetic Technician's individual discretion and judgement under the guidance, direction and monitoring of the Clinical RDN/LDN Supervisor or assigned dietician. 4. The RDN/LDN directs the nutrition care process and collaborates with the Consultant Dietetic Technician and the IDT team to ensure that nutrition needs are met to promote achievement of goals. Review of the Facility Policy titled, Documentation in Medical Record with an implemented date of 04/02/24 included in part the following: 1. Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law as facility policy. 2. Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. When documentation occurs after the fact, outside acceptable time limits, the entry shall be clearly indicated as late entry. Review of revised 2024 Scope and Standards of Practice for the Nutrition and Dietetics Technician, Registered by the Commission on Dietetic Registration the credentialing agency for the Academy of Nutrition and Dietetics Published January 2024 which can be found at https://www.cdrnet.org/vault/2459/web/Scope%20Standards%20of%20Practice%202024%20NDTR_FINAL.pdf included in part the following: For the NDTR, scope of practice and standards of practice are a comprehensive framework describing the competent level of NDTR practice and professional performance expected from NDTRs whatever their practice levels or setting. The scope of practice focuses on food, nutrition, and dietetics practice, as well as related services. NDTRs work under the clinical supervision of an RDN (i.e., nutrition care process and workflow elements applied to direct care).* NDTRs may work independently in providing general nutrition education to healthy populations, consulting to foodservice business and industry, conducting nutrient analysis, collecting data, and conducting research, and managing food and nutrition services in a variety of settings. The scope of practice for each NDTR has flexible boundaries that is defined by the individual NDTR's education, training, credentialing, experience, and demonstrated and documented competence. The majority of NDTRs are employed in health care or public health settings as RDN/NDTR team members working under the supervision of RDNs or as members of RDN/NDTR teams within interprofessional health care teams. As a member of the RDN/NDTR team, the NDTR interacts with health care practitioners (e.g., physicians, nurses, nurse practitioners, pharmacists, speech-language pathologists, occupational therapists, physical therapists, social workers, exercise physiologists, respiratory therapists) and others to obtain and communicate information that contributes to nutrition assessment and assists with implementation and monitoring of the patient's/client's nutrition intervention plan, which is developed and directed by the RDN. RELATIONSHIP OF THE RDN WITH THE NDTR IN DELIVERING HIGH QUALITY NUTRITION CARE As a member of the RDN/NDTR team, the NDTR supports the RDN by providing key oversight and communication concerning delivery of quality person-centered food and nutrition services.* The NDTR and other professional, technical, and support staff work under the clinical supervision of the RDN when engaged in direct patient/client nutrition care activities in any setting. The RDN is responsible for nutrition care assigned to and completed by NDTRs and other staff, and is accountable to the patient/client, employer/organization, and regulator. Additional considerations include state dietitian/nutritionist practice acts and regulations that may define supervision, and if applicable, statutory scope of practice specifications for technical and other assistive staff. Federal and state rules and regulations for health care facilities specify that the qualified dietitian must supervise the nutritional aspects of patient care and provide nutrition assessments and dietary counseling. NDTRs working in skilled or long-term care facilities as the food and nutrition director/manager follow the facility/organization protocol to work in collaboration with the RDN to address a resident's diet- or nutrition related orders, including when the physician has delegated diet order writing to the RDN. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The degree of direction and supervision is determined by the RDN based on the medical and nutritional complexity of the patient/client needs and the training, experience, and demonstrated and documented competence of the NDTR. Direct and indirect supervision of nutrition care services/nutrition care process is when the supervising RDN is available to the NDTR for consultation when it is required. Whether the supervision is direct (RDN is on premises and immediately available) or indirect (RDN is immediately available by telephone or other electronic means) is determined by regulation and facility/program policies and procedures. This description of supervision as it relates to the RDN/NDTR team is not the same as managerial supervision or clinical supervision used in medicine and mental health fields (e.g., peer to peer), supervision of provisional licensees, and/or supervision of dietetics interns and students.* In direct patient/client care, the RDN and NDTR work as a team using a systematic process reflecting the Nutrition Care Process and workflow elements and the organization's documentation system, for example, an electronic health record that uses one of the available standardized terminologies that may incorporate the electronic Nutrition Care Process Terminology (eNCPT). The RDN develops and oversees the system for delivery of person-centered nutrition care activities, often with the input of others, including the NDTR. Patient/client populations include individuals receiving person-centered care who have medical conditions or diseases, as well as at-risk individuals receiving personalized nutrition guidance as part of preventive health care. The RDN is responsible for completing the nutrition assessment; determining the nutrition diagnosis or diagnoses; developing the care plan; implementing the nutrition intervention; evaluating the patient's/client's response; and, also supervising the activities of professional, technical, and support personnel assisting with the patient's/client's care.* RDNs assign duties that are consistent with the NDTR's individual scope of practice. For example, the NDTR may initiate standard procedures, such as completing and/or following up on nutrition screening for assigned units/populations/patients/clients, performing routine activities based on diet order and/or policies and procedures, completing the intake process for a new clinic patient/client, and reporting to the RDN when a patient's data suggest the need for an RDN evaluation. The NDTR actively participates in nutrition care by contributing information and observations, guiding patients/clients in menu and snack selections, monitoring meals/snacks/nutrition supplements for compliance to diet order and providing nutrition education on prescribed diets. The NDTR reports to the RDN on the patient's/client's response, including documenting outcomes or providing evidence signifying the need to adjust the nutrition intervention/plan of care.The Care Process and Workflow element for Nutrition Assessment and Reassessment lists the RDN Role as Perform and document results of initial and follow-up assessment(s) and list the NDTR Role as Per RDN request or standard procedure, obtain and document specified data to contribute elements of the nutrition assessment or reassessment for completion by the RDN. The Care Process and Workflow element for Nutrition Monitoring and Evaluation lists the RDN Role as Determine and document outcome of interventions reflecting input from all sources and lists the NDTR Role as Implement/oversee duties performed by other nutrition and foodservice staff; monitor patient/client tolerance and acceptance of meals, snacks, nutritional supplements; document per procedure; and report to the RDN and other team members the results and observations of monitoring activities. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1.) Record review for Resident #12 revealed the resident was originally admitted to the facility on [DATE] with the most recent readmission on 11/08/24. The resident's diagnoses included in part the following: Osteomyelitis of Vertebra Thoracic Region, Discitis Unspecified Thoracic Region, Encounter for Surgical Aftercare Following Surgery on the Nervous System, Pressure Ulcer of Right Buttock Stage 4, Seizures, Dysphagia Following Cerebral Infarction, Other Specified Disorders of Brain, Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side. Review of the Minimum Data Set (MDS) assessment for Resident #12 dated 11/29/24 documented in Section C a Brief Interview of Mental Status score of 15 indicating a cognitive response. The Care Plan for Resident #12 initiated 05/29/24 with a focus that the Resident has potential for weight loss, slow healing and altered nutrition/hydration status. The goal was for the resident's nutrition and hydration needs to be met as evidenced by improved skin status and labs as medical condition allows. The interventions included in part the following: RD (Registered Dietitian) to evaluate and make diet recommendations PRN (as needed). The Nutrition/Dietary Note for Resident #12 dated 12/31/24 by Staff A DTR (listing position as Dietician) documented in part the following: DTR wound review: Resident followed by wound care MD for stage 4 pressure ulcer to sacrum, 9 x 6.7 x 1.2cm. Wound vac in place. NSA liquid protein and Ensure plus offered for nutrition and wound healing support. Wound improving per wound MD report 12/30/24. Oral intake mostly 76-100% of regular diet. No problems chewing or swallowing, resident can feed self and make needs known. Current body weight: 175.4 pounds (11/26/24). Triggered for significant weight loss x 30days, interventions ordered and resident refusing weekly weights for one month. No updated meal preferences, no complaints voiced. Labs 12/02/24: Hgb 8.9L, Hct 27.8L. Estimated nutritional needs: 2400-2800 kcal (30-35 kcal/kg), 100-120g pro (1.25-1.5g/kg), 2400-2800 ml fluids (30-35 ml/kg). Care plan reviewed; nutrition risks continue. Recommend adding Expedite 2.0 60 ml daily to aide w/wound healing, provides additional 100 kcal/10g protein. RD/DTR to follow and remain available prn. Review of the Nutrition/Dietary Notes for Resident #12 dated 01/21/25, 01/23/25, 01/29/25, and 01/31/25 authored by Staff C Registered Dietitian (RD) did not document any review or collaboration of Staff A DTR note from 12/31/24. The Nutrition/Dietary Note for Resident #12 dated 02/06/25 by Staff A DTR (listing position as Dietician)documented the following: DTR progress note: resident refused weekly weight; staff respects resident's right to refuse. Recommend continuing interventions and weekly weights as tolerated. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105083	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broward Nursing & Rehabilitation Center	1330 S Andrews Ave Fort Lauderdale, FL 33316

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Nutrition/Dietary Note for Resident #12 dated 02/12/25 by Staff A DTR (listing position as Dietician) documented in part the following: DTR weight/wound review: Estimated nutritional needs: 2190-2555 kcal (30-35 kcal/kg), 95-109g pro (1.3-1.5g/kg), 2190-2555 ml fluids (30-35 ml/kg). Resident #12 presents with significant weight loss x 90 and 180 days, weight currently stable x 30 days. Interventions currently ordered for nutrition and wound healing support include Ensure plus, 8 oz twice daily, NSA liquid protein 30 ml daily, Eldertonic for appetite, fortified pudding 3 times weekly. Oral intake improved, 51-100% of most meals and 100% of supplements ordered. Resident also accepts snacks daily and receives foods from family. Met w/resident. Meal preferences reviewed. He had no food complaints or concerns, stated he is eating better and is taking the Ensure as ordered. No changes wanted to meals at this time. Resident is aware that he has lost weight, and stated he would like to weigh around 170 pounds. He understands the importance of good nutrition and hydration for healing and strength, and he feels he is eating well at this time. Wound to sacrum is improving. Care plan reviewed. Resident may be at risk for further unavoidable weight loss r/t multiple comorbidities and increased needs for impaired skin. Current intake of meals, snacks and supplements should be sufficient to meet needs as evidenced by stable weight and improved wounds. Recommend: continue supplements as ordered, continue weekly weight monitoring as tolerated as resident often refuses to be weighed. RD/DTR in collaboration and agree with plan of care, RD/DTR to follow weight, po intake, skin and labs as available. The Nutrition/Dietary Note for Resident #12 dated 02/12/25 linked to note dated 02/12/25 by Staff A DTR documented, Revised and agreed with plan of care, Co-signed by Staff D RD/LD. In summary the Nutrition/Dietary Notes for Resident #12 authored by Staff A DTR 12/31/24 and 02/206/25 were inaccurately authored by Staff A as evidenced by listing her title as a Dietitian when she is not a Dietitian, she is a Dietetic Technician, Registered. Furthermore, neither of these notes were reviewed by a RD. 2.) Record review for Resident #58 revealed the resident was originally admitted to the facility on [DATE] with most recent readmission on 11/06/24. The diagnoses for the resident included in part the following: Gastrostomy Malfunction, Secondary Malignant Neoplasm of Unspecified Site, Dementia, Aphasia Following Other Cerebral Disease, and Flaccid Hemiplegia Affecting Left Nondominant Side. The Minimum Data Set (MDS) assessment for Resident #58 dated 01/15/25 documented in Section C a Brief Interview of Mental Status was not completed due to the resident is rarely/never understood. Review of the Physician's Orders for Resident #58 revealed an order dated 12/04/24 for every shift Jevity 1.5 (formulary type) at 50 milliliters/hour for 20 hours from 2:00 PM to 10:00 AM via G-tube via pump (providing 1000ml/1500 Kcal/15 units every 24 hours indefinitely. The Care Plan for Resident #58 initiated on 12/20/17 with a focus that Resident may be at nutritional risk related to enteral nutrition dependence/NPO (nothing by mouth). The goal was for nutrition and hydration needs to be met as evidenced by no significant weight change and no signs/symptoms of intolerance by next review date. The interventions included: RD (Registered Dietitian) to evaluate and make tube feeding change recommendations as PRN (as needed). The Enteral Nutrition Evaluation Note for Resident #58 dated 12/30/24 authored by Staff A DTR (listing position as Dietician) documented in part the following: (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Estimated Needs: Kcal: 1193-1418 kcal, Protein: 58-69g (1.1-1.3g/kg) Fluids: 1590-1855 ml 30-35 ml/kg Enteral Formula: Jevity 1 Enteral Nutrition Evaluation Note for Resident #58 dated 12/30/24.5 continuous Rate: 50 ml/hr x 20 hours (1000 ml total) Time: 20 hours Flushes: 45 ml/hr x 20 hours (900 ml) Provided Calories: 1500 kcal Protein: 64g protein Fluid: 1660 total water Recommendations: Current TF (tube feeding) regimen adequate to meet needs at this time. Weight in stable range w/no significant weight changes x 30/90/180 days. Recommend: continue TF and flushes as ordered, d/c (discontinue) weekly weights. RD/DTR to follow and remain available prn (as needed). The Nutrition Evaluation for Resident #58 dated 01/21/25 authored by Staff C Registered Dietitian (RD) revealed no documentation of reviewing, collaborating or approving of assessment and recommendations of the Enteral Nutrition Evaluation Note for Resident #58 dated 12/30/24 authored by Staff DTR (listing position as Dietitian). The Nutrition/Dietary Note for Resident #58 dated 02/12/25 authored by Staff B Registered Dietitian/Licensed Dietitian (RD/LD) documented the following: This note is a follow up to: 12/30/24 Enteral Nutrition Evaluation Note [Author: Staff A Dietetic Technician, Registered (DTR)] Documentation reviewed and approved; continue to collaborate on resident care with DTR. In summary the Enteral Nutrition Evaluation Note for Resident #58 dated 12/30/24 authored by Staff A DTR was inaccurately authored as evidenced by listing her title as a Dietitian when she is not a Dietitian she is a Dietetic Technician, Registered. Furthermore, the note was not reviewed by a RD in a timely manner, as evidenced by it not being reviewed until 02/12/25 over 6 weeks after the evaluation was written by Staff A DTR. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview conducted on 02/12/25 at 1:50 PM with the Director of Clinical Services (DCS) who stated she has worked with the facility for [AGE] years. When asked about contracted dietary staff specifically the Dietitian and Dietetic Technician, Registered (DTR) she stated the company they contract with would do the credentialling and she would be one of the personnel who entered their information into the facility's electronic computer system. When asked about Staff A Dietetic Technician, Registered (DTR), she said she is in their system as a Dietitian. When asked if Staff A DTR is a Dietitian, she stated no, she is a DTR. When asked why she was entered into the electronic system as a Dietitian, she said they probably did not have a drop down for DTR. When the DCS checked the electronic system, she said we do have a drop down, so they must have put her in their system as Dietitian so she would have access to additional information such as weights and lab work. The DCS acknowledged Staff A DTR was in their electronic system and had an electronic signature with title of Dietitian when it should be DTR. During an interview conducted on 02/12/25 at 1:55 PM with the Administrator who was asked if the DTR did not have access in the electronic system to resident's information would the facility be able to print the information such as weights and lab work for the DTR, she said yes, the DTR would just need to ask for the information. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview conducted on 02/13/25 at 10:09 AM with Staff A Dietetic Technician. Registered (DTR) who stated she has been coming to this facility since July 2024 and has been with the contracted company for 6 years. Also present for the interview was Staff D Registered Dietitian/Licensed Dietitian (RD/LD) who stated she has been with the contracted company since 01/27/25 and coming to this facility for about 1 week. When Staff A DTR was asked about her title in the facility's electronic system she acknowledged it was listed as Dietitian. Staff A DTR added she believes it is this way for her to be able to have access and to view items for various residents. Staff A - DTR stated she works under the direction of a Registered Dietitian (RD) who works for the same contracted company as her, it may be the RD in the facility, or it could be a remote RD. Staff A DTR stated she sends her reports on a tracking sheet to her immediate supervisor Staff B Registered Dietitian (RD) to show her work and any recommendations she may have for a resident. Staff A DTR was asked if she does assessments, evaluations, estimate needs and make recommendations, she said yes this is within her scope of practice. Staff A DTR stated she can do all of it. When Staff A DTR was asked about the process of the RD reviewing her work she stated they verify her work by going into the facility's electronic system for the residents and sign off by linking their note to her note. Staff D RD/LD who was asked about reviewing the work of the DTR she will go into the DTR assessment/evaluation in the facility's electronic system and unlock the assessment/evaluation, write her comments/recommendations and if she agrees or disagrees with the plan of care then she will co-sign the assessment/evaluation and lock it. Staff D RD/LD stated if the DTR makes a note, she as the RD will make her own note and link it to the DTR's note. Staff D RD/LD was asked what is the expected time frame for her to review and document about the DTR's assessment/evaluation or notes, she said within 1-2 days. Staff A DTR then had the Owner who is also a Registered Dietitian (RD) join the conversation via telephone. The Owner/RD stated she has owned the contracted company for [AGE] years. The Owner/RD was asked if Staff A DTR can assess/evaluate, estimate needs and make recommendations she stated it would depend if Staff A DTR feels comfortable doing those things. When the Owner/RD was asked who is responsible for providing oversight to Staff A DTR, she said it could be any RD in the company including her direct supervisor Staff B RD and they would review Staff A DTR's work under their guidance. When asked what the expected time frame for a RD to review and document on Staff A DTR's work, the Owner/RD stated the work would be reviewed and addressed within 1 week. Staff A DTR was then asked to pull up documentation for Resident #58 and she acknowledged her Enteral Nutrition Evaluation Note dated 12/30/24 was not documented as reviewed by Staff B RD until 02/12/25. Staff A DTR said she believed this was an isolated incident. Staff A DTR was then asked to pull up documentation for Resident #12 and she acknowledged her Nutrition/Dietary Note from 12/31/24 was not documented as reviewed by Staff B RD until 02/12/25. When asked if she thinks there are additional residents with documentation of her assessments/evaluations/notes not being reviewed timely by a RD, she said potentially.