STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105237	A. Building B. Wing	10/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broward Oaks Nursing and Rehabilitation	7751 W Broward Blvd Plantation, FL 33324

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105237	A. Building B. Wing	10/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broward Oaks Nursing and Rehabilitation	7751 W Broward Blvd Plantation, FL 33324

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to follow the professional standards for the care and management of pressure ulcers for 1 of 2 residents reviewed for wound care (Resident #1). The findings included: According to the Center for Medicare and Medicaid Services (CMS), avoidable pressure ulcer injury means the resident developed a pressure ulcer/injury, and the staff failed to do one or more of the following : Evaluate the resident's clinical condition and risk factors. Define and implement interventions that are consistent with resident needs and goals and follow professional standards of practice. Monitor and evaluate the impact of the interventions. Revise interventions as appropriate. A record review revealed Resident #1 was admitted to the facility on [DATE] and was transferred to a hospital on 9/26/25. The admitting diagnoses included in part, Cerebral Aneurysm, Atherosclerotic Heart Disease of Native Coronary Artery without Angina Pectoris, Reflux Uropathy, Essential Hypertension and Spondylosis without Myelopathy or Radiculopathy of the Lumbar region. A review of the admission Minimum Data Set (MDS) assessment dated [DATE] under Section C for the Brief Interview for Mental Status (BIMS) revealed a score of 14, indicating Resident #1 had no cognitive impairment. Section GG documented this resident was staff dependent on eating, personal hygiene, toileting, and upper and lower body dressing. Section M documented a no response to the presence of a pressure ulcer or injury, and pressure ulcer and injury care. An additional review of electronic nursing care plan with focus on skin integrity related to history of healed wound was initiated on 8/20/25. On 9/1/25, another focus indicating the old pressure ulcer was reopened and treatment was initiated; and an additional focus was added on 9/10/25, with a note documenting the wound worsened, reevaluated, and changed. An electronic nursing care plan review documented the intervention for wound care consult was added on 9/8/25, approximately 4 weeks after Resident #1's admission to the facility. Additional review of nursing interventions documented that the air mattress was added on 9/10/25, and the wedge cushion to reposition and off load to be placed under the back every shift was initiated on 9/25/25, indicating both air mattress and wedge cushions were added approximately 5, and 7 weeks after Resident #1's admission to the facility. In an interview conducted with Wound Care Licensed Practical Nurse (LPN) on 10/7/25 at 11:20 AM, when she was asked the process of skin assessment during admission, she responded, If no skin issues are found, but if there are risks. she will initiate an air mattress order for preventative measure. She added that the resident might get the air mattress in a couple of hours after admission. If admitted before 4:30 PM, the mattress will be issued within the first 2 hours of admission to the facility. If admitted late at night, the mattress will be provided to the resident on the following day. She added that the facility has uploaded wedges, pillows, donut and cushion for wheelchairs. All the Inter Disciplinary Team (IDT) members, Central Supply personnel and Therapy staff will coordinate the care of a resident who has skin risk assessment for pressure ulcer and they will decide which preventative measures would be appropriate. She stated that within 2 days after admission, a resident who is at risk for skin breakdown will have the necessary supplies to prevent the development of pressure ulcer. She added that they have weekly skin check, where the Nurse will go in and observe the body for any new areas forming and document the findings in the computer, on skin observation under the assessment tab. When she was asked if it is possible to have stage 4 pressure ulcer after a month of staying in the facility, she stated that it would first start with visible skin issues like redness, excoriation, deteriorating, then stage 1, but usually not stage 4 right away. She had not witnessed a resident who did not have any skin opening during admission and then a month later turned into stage 4 pressure ulcer. When she was asked if there was a facility acquired pressure ulcer in September 2025, she responded, Resident #1, because this resident came in with scar tissue on the sacrum, which was closed, and with no drainage. I did not take a picture of the sacrum during admission, and I wrote buttocks on her nursing admission skin assessment which was electronically submitted on 8/20/25. I performed the skin assessment on 8/20/25, but I corrected the word buttocks into sacrum later. She added that she initiated preventive measures like barrier cream, offloading measures, wedges and air mattress, but wedges and air mattress were not provided to Resident #1 because the resident had no open wound on admission. When she was asked if there were risk for the development of pressure ulcer for this resident, she responded that this resident had a risk of developing pressure ulcer. She ordered the air mattress and wedges on 09/09/25, which was approximately 3 weeks after Resident #1's admission to the facility. She ordered them because the resident was not thriving. The resident was refusing to eat, drink

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105237	A. Building B. Wing	10/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broward Oaks Nursing and Rehabilitation	7751 W Broward Blvd Plantation, FL 33324

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105237	A. Building B. Wing	10/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broward Oaks Nursing and Rehabilitation	7751 W Broward Blvd Plantation, FL 33324

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to follow the professional standards of practice for the care and management of an indwelling urinary catheter and failed to follow their own policy for catheter care for 2 of 2 residents reviewed for urinary care (Resident #1 and Resident #3). The findings included:According to the Center for Disease Control and Prevention (CDC), in the non-acute care setting. Properly secure indwelling catheters after insertion to prevent movement and urethral traction. (p.12). Education and performance feedback regarding appropriate use, hand hygiene, and catheter care (p.15). https://www.cdc.gov/infection-control/media/pdfs/Guideline-CAUTI-H.pdf According to the facility's policy titled, Catheter Care, implemented on 12/17/17, it documented that it is the policy of this facility to ensure that residents with indwelling catheter receive appropriate care and maintain their dignity and privacy when indwelling catheters are in use. Catheter care will be performed every shift and as needed by nursing personnel. 1) A record review revealed Resident #1 was admitted to the facility on [DATE] and was transferred to a hospital on 9/26/25. The admitting diagnoses included in part, Cerebral Aneurysm, Atherosclerotic Heart Disease of Native Coronary Artery without Angina Pectoris, Reflux Uropathy, Essential Hypertension and Spondylosis without Myelopathy or Radiculopathy of the Lumbar region. A review of admission Minimum Data Set (MDS) assessment dated [DATE] under Section C for the Brief Interview of Mental Status (BIMS) revealed a score of 14, indicating Resident #1 had no cognitive impairment. Section GG documented this resident was staff dependent on eating, personal hygiene, toileting, and upper and lower body dressing. Section H revealed a yes response to indwelling catheter. An additional review of physician order dated 8/4/25, documented to provide (Foley) indwelling catheter care, every shift, and secure catheter with a holder to prevent migration, every shift. A further review of orders did not include Enhanced Barrier Precaution (EBP), when the urinary catheter care was ordered. A record review of facility's EBP policy with implementation date of 11/20/21 revealed an order for EBP will be obtained for residents with wounds and or indwelling medical devices (e.g. urinary catheter) regardless of Multiple Drug-Resistant Organism (MDRO) colonization status. In an interview conducted with the Infection Control Licensed Practical Nurse on 10/07/25 at 1:35 PM, when she was asked if a resident with a urinary catheter should be under EBP guidelines, she responded, Yes. When she was asked when the resident will be under EBP guidelines, she responded, as soon as the resident was ordered to have a urinary catheter. A further review of nursing care plan revealed that the EBP focus related to urinary catheter was not initiated until 9/26/25, indicating it was added approximately 7 weeks after Resident #1's admission to the facility. 2) A record review revealed Resident #3 was admitted to the facility on [DATE] with diagnoses that included Hemiplegia and Hemiparesis following Non-Traumatic Intracerebral Hemorrhage affecting the Left Nondominant Side, Obstructive and Reflux Uropathy, Hypertensive Chronic Kidney Disease and Cognitive Social and Emotional Deficit following Nontraumatic Intracerebral Hemorrhage. A review of the quarterly MDS assessment dated [DATE], under Section C, revealed a BIMS score of 12, indicating Resident #3 had moderate cognitive impairment. Section H revealed a yes response to indwelling catheter. An electronic record review of physician orders dated 8/12/25, documented indwelling urinary catheter of size 16, with inflation balloon of 10 ml (milliliter) sterile water for the diagnosis of Obstructive Uropathy. An additional review of physician order dated 8/4/25, documented to provide (Foley) indwelling catheter care, every shift, and secure catheter with a holder to prevent migration, every shift. During a urinary care observation and interview conducted on 10/7/25 at 2:58 PM, with Staff G, a Restorative Certified Nursing Assistant (CNA), and Staff I, another CNA, who when asked about the color and the urine consistency, both stated the color was pinkish, cloudy and with sediments noted in the urinary tubing. Additional observation revealed Resident #3's catheter was not secured on the thigh but freely moving when the resident moved. Both staff CNAs stated that the secure lock was not secured and not dated. When Staff I, a CNA was asked if she frequently provides urinary catheter care to Resident #3, she responded, Yes, every time I am assigned to him. When she was asked if the secure system is always attached to the resident's, she responded, Sometimes. When she was asked if she reattaches the secure system (anchor)when it becomes detached, she responded, Nurses do that. When she was asked if she will tell the staff Nurse regarding the detachment of the secure system, she responded, I always tell the Nurse. During the same urinary care observation, Staff I, CNA did not change her gloves from beginning until the end. When she was asked why she kept the same gloves for cleaning the resident's