STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105298	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FT Lauderdale Health & Rehabilitation Center	2000 East Commercial Blvd Fort Lauderdale, FL 33308

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to accurately assess residents for a psychiatric diagnosis for 1 of 2 sampled residents reviewed for Preadmission Screening and Resident Review (PASARR), Resident #15. The findings include:Record review revealed Resident #15 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis of Schizoaffective Disorder, Bipolar type and Major Depressive Disorder, recurrent, moderate. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident's Brief Interview of Mental Status (BIMS) score was 15, which indicates no cognitive impairment. Record review revealed Resident #15 had a diagnosis of bipolar disorder on 05/10/24, schizoaffective disorder, bipolar type on 05/10/24 and major depressive disorder, recurrent and moderate on 12/02/24. Record review revealed Resident #15 was admitted to the facility with a hospital discharge diagnosis of recent UTI [Urinary Tract Infection], with a history of Hypertension, history of Hyperlipidemia, history of Diabetes Mellitus and schizoaffective disorder bipolar type. In an interview conducted on 03/12/26 at 12:00 PM, the Director of Social Services revealed that she has been working for the facility for 4 years. She further stated that residents are admitted to the facility essentially with a PASARR level 1. An admission evaluation is completed by Social Services and the admission PASARR is reviewed. Upon the review, a brief review of the hospital documentation and the resident's admitting diagnosis is evaluated to see if there are any behaviors and psychiatric diagnosis. If any corrections need to be made, she communicates with admission or the care plan coordinator to make the necessary changes. Review of Resident #15's PASARR dated 03/17/24 from the hospital revealed there was no psychiatric diagnosis documented on the discharge paperwork from the hospital. Record review indicated that an updated PASARR with the psychiatric diagnosis was done on 11/15/25. In an interview conducted on 03/12/26 at 12:20 PM with the MDS Coordinator, she stated that she has been working in the facility for 4 years now. She further stated that she is the one responsible for inputting the diagnosis in point click care (PCC). Per surveyors' question about the origin diagnosis of schizoaffective disorder, bipolar type, major depressive disorder, recurrent, moderate and bipolar disorder, current episodic manic without psychotic, the MDS Coordinator explained that it came from a psychiatric note written by the Psychiatric Nurse Practitioner and not from the hospital record. In a phone interview conducted on 03/12/26 at 1:15 PM, the Psychiatric Nurse Practitioner stated that he started working with Resident #15 about a year ago and asked for an audit on the diagnosis of bipolar disorder and major depressive disorder for about 6 months now. He also explained that the two previous diagnoses can get discarded because the only sustainable diagnosis is schizoaffective disorder, bipolar type. In an interview conducted on 03/12/26 at 1:45 PM, the Director of Nursing (DON) stated that they have monthly psychiatric meetings and were not aware of an audit being requested by the Psychiatric Nurse Practitioner regarding Resident #15. The DON also acknowledged that a diagnosis of Schizoaffective disorder Bipolar type is different from a diagnosis of Schizoaffective disorder and another diagnosis of Bipolar disorder. A review of the progress notes indicated that on 03/12/26, after surveyors' intervention, a note was put in place stating: Based on the patient's recent clinical presentation and behavioral observations, the diagnosis of bipolar disorder has been discontinued due to insufficient clinical evidence supporting the presence of manic or hypomanic episodes.

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
	105298	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FT Lauderdale Health & Rehabilitation Center	2000 East Commercial Blvd Fort Lauderdale, FL 33308

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of policy and procedure, record review and interview, the facility's failed to ensure that it followed physician's orders and documented nursing interventions for a resident's elevated Blood Sugar Levels (BSL), when out of range, for 1 of 4 sampled residents reviewed for Nutrition, Resident #146.The findings included:Review of the facility's policy, provided by the Director of Nursing (DON), documented in the Policy Statement, as follows, Purpose: To provide guidelines for the safe administration of insulin to residents with Diabetes. Preparation:.3. The type of insulin dosage requirements, strength, and method of administration must be verified before administration, to assure that it corresponds with the order on the medication sheet and the physician's order. 4. The nurse shall notify the Director of Nursing Services and Attending Physician of any discrepancies, before giving the insulin.Steps in the Procedure (Insulin injections via Syringe).2. Check blood glucose per physician's order or facility protocol.Documentation: 1. The resident's blood glucose result, as ordered. 2. The dose and concentration of the insulin injection; 3. Size and gauge of the needle used for injection; 5. How well the resident tolerated the procedure. Reporting:.2. Notify the physician if the resident has signs and symptoms of Hypoglycemia that are not resolved by following the facility protocol for hypoglycemic management. Record review revealed Resident #146 was originally admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included Encephalopathy, Diabetes Mellitus Type II, Dementia, Hypertensive Heart and Chronic Kidney Disease (stage 4 severe), Unspecified Convulsions and Major Depressive Disorder. She had a Brief Interview Mental Status (BIMS) score of 00, indicating severe cognitive impairment.Further record review revealed the following:On 09/22/25 the physician's order documented, Novolin R FlexPen Injection Solution Pen-injector 100 unit/ml Inject as per sliding scale: if 150 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units if greater than 400 give 10 units and call MD.On 02/07/26 at 16:42 PM, the February 2026 Medication Administration Record (MAR) documented, Novolin R FlexPen Injection Solution Pen-injector 100 unit/ml Inject as per sliding scale: if 150 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units if greater than 400 give 10 units and call MD, per Staff G.On 02/22/26 at 12:34 PM and at 16:39 PM, again the February 2026 MAR, Novolin R FlexPen Injection Solution Pen-injector 100 unit/ml inject as per sliding scale: if 150 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units if greater than 400 give 10 units and call MD, subcutaneously before meals for DM 2 Hold for BG less than 70; Notify MD 10 units w/ routine given, per Staff G.Review of Resident #146's Diabetes Mellitus II Care plan, initiated on 07/01/25 and revised on 01/13/26, documented as follows, Focus: Diabetes Mellitus- Resident is at risk for complications related to diagnosis of Diabetes Mellitus. Interventions:. Medication as ordered. Monitor blood sugar as ordered with Accu check and administer coverage insulin as ordered and needed. Notify physician if problems occur. Observe for signs and symptoms of complications of disease process and report problems. Observe for signs and symptoms of hyper/ hypoglycemia reaction and report episode to physician. Goal: Resident will remain free of hyper/hypoglycemia episodes with insulin sliding scale through next review date. will remain free of complications related to diabetes through next review date. Review of the February 2026 MAR revealed documentation that Resident #146 had two (2) routine insulin orders as follows: 1) Insulin Glargine Subcutaneous Solution 100 units/ml (Insulin Glargine) inject thirty (30) unit subcutaneously at bedtime for Diabetes Mellitus II and 2) Novolin R Flex Pen Injection Solution Pen-injector 100 units/ml (Insulin Regular (Human) inject eight (8) units subcutaneously (SQ) before meals for Diabetes Mellitus II hold for blood glucose less than (<) 70; Notify Medical Director (MD).Further review of the February 2026 MAR revealed that Staff G had initialed and recorded on three (3) different occasions: 02/07/26 at 16:42 PM, 02/22/26 at 12:34 PM, and 02/22/26 at 16:37 PM, that Resident #146's Blood Sugar Level (BSL) measured well over 400 mg/dl as: 471.0 mg/dL, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105298	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FT Lauderdale Health & Rehabilitation Center	2000 East Commercial Blvd Fort Lauderdale, FL 33308

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	407 mg/dl and 411 mg/dl, respectively.However, there was no notation anywhere in the MAR or nurses notes to show that Resident #146's physician had ever been notified of the resident's elevated BSL, as ordered. Nor was there any documented response to this, in the record, from the physician.Record review of Resident #146's BSL ranges from 01/01/26 thru 03/11/26 revealed that they were from 80 mg/dl up to 471 mg/dl.On 03/12/26 at 11:10 AM an interview was conducted with Staff B regarding the process by which a nurse is to follow for a resident when there is a physician's order to administer insulin to the resident, as well as call or notify the physician if the resident's BSL is above 400 mg/dl. She stated that when the nurse administers the sliding scale insulin and initials the MAR box, this order only populates on the MAR, and in the nurses' progress notes. She went on to say that the nurse would still have needed to document the follow-up, or re-checked the BSL in order to determine the effectiveness of the sliding scale insulin medication to see if it remained greater than (>) or less than (<) 400, or not, in order to have an accurate reading to contact the physician for a clear directive.An interview was conducted on 03/12/26 at 1 PM with Staff A LPN, in which she acknowledged that there were three (3) different instances in which the resident displayed an episode of elevated BSL greater than 400 in which there was no documentation of Resident #146's physician being notified, as ordered.Am interview was conducted on 03/12/26 at 1:15 PM with Staff F, Registered Nurse (RN)/Unit Manager (UM) for 2nd and 3rd floors, regarding the process by which a nurse is to follow for a resident when there is a physician's order to administer insulin to the resident, as well as call or notify the physician if the resident's BSL is above 400 mg/dl. Staff F stated that when the nurse administers the sliding scale insulin with parameters and initials the MAR box, this order only populates on the MAR, and in the nurses' progress notes. She went on to say that the nurse would still have needed to document in the nurses' progress note that a follow-up, or re-checked BSL was done in order to determine the effectiveness of the sliding scale insulin medication to see if it remained greater than (>) or less than (<) 400, or not, in order to have an accurate reading to contact the physician for a clear directive. She also acknowledged that there were three (3) different instances in which the resident displayed an episode of elevated BSL greater than 400 in which there was no documentation of Resident #146's physician being notified, as ordered.Interview conducted on 03/12/26 at 1:25 PM with ADON, RN/Assisted Director of Nursing (ADON)/Nurse Supervisor, in which she also acknowledged that three (3) different instances in which the resident displayed an episode of elevated BSL greater than 400 mg/dl, in which there was no documentation to show that Resident #146's physician had been notified, as ordered.A telephone interview was conducted on 03/12/26 at 1:40 PM with Staff G, in which she acknowledged that there were three (3) different instances that she recorded and documented, in which the resident displayed an episode of elevated BSL greater than 400 in which there was no documentation of Resident #146's physician being notified, as ordered.During an interview on 03/12/26 at 1:27 PM, the DON acknowledged that the physician's order should have been followed and the nurse should have notified the physician, as ordered and documented her interventions in the resident's record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105298	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FT Lauderdale Health & Rehabilitation Center	2000 East Commercial Blvd Fort Lauderdale, FL 33308

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 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 interview, record review, and observation, the facility failed to accurately assess residents for safe smoking for 1 of 2 sampled residents reviewed for smoking, Resident #81. The findings included:The findings include:Record review revealed the facility's smoking evaluation contained the following assessment prompt: Resident smokes safely. (Does not allow ashes or lit material to fall while smoking, inhaling, or holding item. Remains alert and aware while smoking. Does not forget he/she is smoking or fall asleep holding item. Does not endanger self or others while smoking. Does not burn furniture, clothing, skin, self or others. Turns oxygen off prior to lighting cigarette. Smokes only in designated areas). Record review revealed Resident #81's last Quarterly MDS (Minimum Data Set) assessment dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 5/15, which indicates severe cognitive impairment. Further record review revealed Resident #81 was last evaluated as a safe smoker on 01/01/26. On 03/11/26 10:21 AM, Staff F, a Certified Nursing Assistant (CNA) was observed and interviewed while on the smoking patio related to smoking safety. Staff F was asked to identify Resident #81 and stated, that's her and pointed to a women sitting in a wheelchair, with a table in front of her, near the center of the covered patio. Observations revealed Resident #81 was hunched forward in her wheelchair with her head down and her hands below the tabletop. Resident #81's face was not clearly visible because of her posture, and her hands could not be seen by the surveyor who was standing next to Staff F who was sitting behind her supply cart approximately 10 to 15 feet away from Resident #81. Staff F was asked if Resident #81 frequently sits in that position, to which Staff F stated yes, always. Staff F stated she always checks Resident #81 to make sure she is not sleeping before she offers the resident a cigarette. Staff F was observed offering Resident #81 her cigarette and lit it for the resident. The resident resumed her slouching position with her hands and the lit cigarette near her left leg and below the table. The surveyor then introduced himself to Resident #81 and continued the observation. Resident #81 took a puff on her cigarette and then lowered her hand to just above her left knee. The surveyor engaged Resident #81 in conversation while she held her cigarette in the same position. Resident #81 allowed her cigarette to burn without smoking it while answering questions about her care in the facility. The surveyor noted the length of ash on the cigarette and reminded Resident #81 about her cigarette. A small amount of ash had fallen to the ground before Resident #81 tapped the rest of it off in the ashtray. The surveyor then noted a hole on left pant leg by her knee. The resident was asked where the hole came from, she stated it was from this, indicating from her cigarette. She stated she leaves a trail of them on her clothes all the time. Resident #81 stated she has never burned herself from cigarettes. Resident #81 stated she smokes twice a day. On 03/11/26 at 1:12 PM, an interview was conducted with the Assistant Director of Nursing (ADON) regarding Resident #81's smoking evaluation, which the ADON had performed. The ADON was asked if a resident smokes leaning over, below the table level, with her hands near her lap is the resident a safe smoker? The ADON admitted that the resident would not be a safe smoker. The ADON was then asked if she observed Resident #81's clothing for burn marks or holes. The ADON stated she was not aware of any holes or burn marks on the resident's clothing. The ADON stated the holes observed by the surveyor could be from when the resident was at home or another facility. The ADON was asked that since Resident #81 had indicated the hole observed was from smoking and she has a history of burning her clothes would she (the ADON) re-evaluate the resident for safe smoking. The ADON admitted that she had not considered old holes as being an indication of unsafe smoking. The ADON stated that she would do another assessment for safe smoking and reeducate the attendants on safe smoking guidelines.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105298	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FT Lauderdale Health & Rehabilitation Center	2000 East Commercial Blvd Fort Lauderdale, FL 33308

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of policy and procedure, observation, interview and record review, the facility failed to ensure it performed Foley Catheter and Peri-care in a sanitary manner for 1 of 1 sampled residents observed, Resident #10.The findings included: Review of the facility's policy provided by the Director of Nursing titled, Urinary Catheter Care revised on September 2014, documented in the Policy Statement: The purpose of this procedure is to prevent catheter-associated urinary tract infections.Preparation: 1. Review the resident's care plan to assess for any special needs of the resident.General Guidelines: 1. Following aseptic.technique.Infection Control: 1. Use standard precautions when handling or manipulating the drainage system. 2. Maintain clean technique when handling or manipulating the catheter, tubing, or drainage bag.Steps in the Procedure:.7. Wash the resident's genitalia and perineum thoroughly with soap with water. Rinse the area well and towel dry. 8. Pour wash water down the commode. Flush the commode.10. Put on clean gloves. 11. Remove gloves and discard into the designated container. Wash and dry your hands thoroughly.17. Use a clean washcloth with warm water and soap to cleanse and rinse the catheter from insertion site to approximately four inches outward.Record review revealed Resident #10 was originally admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included Metabolic Encephalopathy, Sepsis, Diabetes Mellitus Type II, Obstructive and Reflux Uropathy and Hypertensive Heart Disease Foley Catheter in place. She had a Brief Interview Mental Status (BIMS) score of 9, indicative of moderate cognitive impairment.Further record review revealed on 02/15/26 the physician's orders documented, Indwelling urinary catheter to bedside drainage bag.Reason for catheter: Obstructive and Reflux uropathy.During a Foley/Peri-care Observation conducted on 03/11/26 at 10:30 AM, Resident #10 was observed resting in bed with head of the bed elevated on her right side. The resident provided permission for the surveyor to observe her peri-care. Foley Catheter and Peri-care was observed being performed by Staff L who was assisted by Staff M. The staff members retrieved wearable personal protective equipment (PPE), washed their hands and gathered all of their supplies to begin and complete the resident's Foley Catheter and frontal Peri-care procedure. Next, both staff members turned the resident over on her side and washed her entire buttock area; completing both the Peri-care and Foley catheter care procedure. Afterwards, both staff members were observed turning the resident back over on her back. Staff L then proceeded to return to cleaning and washing the resident's foley catheter tubing area again, without changing her gloves. She was observed using the same cross contaminated water that she had just used previously, for the resident's buttock area. Staff L was not observed changing her gloves frequently throughout the procedure; she wore the same pair of gloves during and throughout the entire peri-care and Foley Catheter care procedure, from front to back and back to front.Review of Resident #10's Bowel and Bladder Care plan initiated on 03/16/23 and revised 02/23/26 indicated Focus: is incontinent of bladder, history of Urinary Tract Infection (UTI). And is incontinent of bowel, at risk for constipation due to impaired mobility.Foley inserted for Obstructive Uropathy Interventions: Change Foley bag per orders. Enhanced Barrier Precaution (EBP) as ordered. Foley catheter care every shift, change bag and catheter as ordered. Keep perineal area clean and dry.Notify MD of signs and symptoms of UTI. Observe for color, odor, and clarity of urine, and report signs and symptoms of infection.Provide incontinence care as needed for bowel incontinence, includes incontinent pads and barrier cream. Use barrier cream as needed to peri area with incontinence care. Goal: Resident will have regular bowel movement with aid of medication through next review date. Resident will have a patent Foley through next review date. Resident will be free of complications from incontinent of bowel thru next review date. On 03/11/26 at 11:24 AM, an interview was conducted with Staff L and with Staff M, regarding the CNA not changing her dirty/contaminated gloves, nor changing the dirty/contaminated basin water, between (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105298	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FT Lauderdale Health & Rehabilitation Center	2000 East Commercial Blvd Fort Lauderdale, FL 33308

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	back and front peri-area care, during the Foley and Peri-care observation and both acknowledged that Staff L should have changed her gloves, and the basin water during the procedure.An interview was conducted on 03/11/16 at 12:08 PM with Staff J, Licensed Practical Nurse, in which she acknowledged that Resident #10's water basin and the CNA's gloves should have been changed during the Foley and Peri care procedure to avoid cross-contamination.An interview was conducted on 03/11/26 at 12:12 PM with Staff F Registered Nurse (RN)/Unit Manager (UM) for 2nd and 3rd floors, in which she acknowledged that Resident #10's water basin and the CNA's gloves should have been changed during the Foley and Peri care procedure to avoid cross-contamination.An interview was conducted on 03/11/26 at 12:17 PM with the RN/Assisted Director of Nursing (ADON)/Nurse Supervisor, in which she also acknowledged that Resident #10's water basin and the CNA's gloves should have been changed during the Foley and Peri care procedure to avoid cross-contamination.The DON further recognized and acknowledged on 03/11/26 at 1:30 PM that appropriate technique should have been performed during Foley catheter and Peri-care in order to avoid cross-contamination.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105298	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FT Lauderdale Health & Rehabilitation Center	2000 East Commercial Blvd Fort Lauderdale, FL 33308

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 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** Based on observations, interviews and record reviews, the facility failed to follow oxygen orders and ensure the MDS (Minimum Data set) assessment was accurate. for 1 of 2 sampled residents reviewed for oxygen therapy (Resident #79). which has the potential to affect 8 residents on oxygen therapy; and the facility failed to obtain physicians order for oxygen therapy administration for 1 of 2 sampled residents reviewed for oxygen therapy (Resident #138).The findings included:Review of the facility policy titled Oxygen Administration provided by the Director of Nursing (DON) revised October 2010 documented in the Policy Statement: The purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation: 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. 2. Review the resident's care plan to assess for any special needs of the resident.Documentation: after completing the oxygen setup or adjustment, the following information should be recorded in the resident's medical record: 1. The date and time that the procedure was performed. 2. The name and title of the individual who performed the procedure. 3. The rate of oxygen flow, route, and rationale. 4. The frequency and duration of the treatment. 5. The reason for PRN (as needed). administration. 6. All assessment data obtained before, during and after the procedure. 7. How the resident tolerated the procedure.9. The signature and title of the person recording the data. 1). Record review revealed Resident #138 was originally admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included Pneumonia, unspecified organism, Chronic Obstructive Pulmonary Disease (COPD) with (acute) exacerbation, Respiratory Failure, unspecified, unspecified whether with hypoxia or hypercapnia, Spondylosis without Myelopathy or Radiculopathy, Lumbar region, Pulmonary Fibrosis, unspecified, Hypertension, Hemiplegia and Hemiparesis following Cerebral Infarction affecting Right Dominant Side and Encephalopathy, unspecified. She had a Brief Interview Mental Status (BIMS) score of 15, indicative of intact cognition. On 03/09/26 at 10:21 AM Resident #138 was observed with Oxygen infusing via nasal cannula at two (2) liters via Oxygen Concentrator. During a brief interview conducted on 03/09/26 at 10:24 AM with Resident #138, she stated that she wears her Oxygen most times during the day and continuously at night, due to having shortness of breath, at times, and she added that she has done so, since being re-admitted into the facility back in September of last year 2025. On 03/09/26 at 4:28 PM through 03/11/26 at 10:08 AM, Resident #138 was still observed with Oxygen infusing via nasal cannula at two (2) liters via Oxygen Concentrator. Record review of Resident #138's Respiratory Care plan originally initiated on 05/11/21 and revised on 12/03/25 indicated Focus: Resident has potential for alteration in breathing pattern related to COPD, shortness of breath, and requires oxygen via nasal cannula as needed. History of Respiratory Failure Interventions: Auscultate lung sounds as needed, elevate head of bed, Lab as ordered, Medication as ordered, Nebulizer treatments as ordered, change tubing per order, O2 per cannula as ordered/as needed (PRN), Oxygen (O2) saturations as needed and O2 tubing changed as ordered. Goal: Resident will be free of respiratory distress through review period. Review revealed that the last discontinued physician's order for Oxygen for Resident #138 was written back on: 08/22/25 at 19:00 PM as: Oxygen at two 2 liters/minute via nasal cannula as needed (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105298	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FT Lauderdale Health & Rehabilitation Center	2000 East Commercial Blvd Fort Lauderdale, FL 33308

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(PRN) for Shortness of Breath (SOB) by Resident #138's attending physician and recorded by Staff H Licensed Practical Nurse (LPN). Additionally, a physician's order dated 09/26/25 documented, SOB while lying flat in bed - monitor every (Q) shift. There was no current physician's ordered in place for the Oxygen therapy administration with parameters. However, record review of the nurses' progress notes revealed that Resident #138 was re-admitted to the facility on [DATE] at 20:55 PM, with. Oxygen documented as currently and actively infusing at two (2) liters .as recorded by Staff I, LPN. Further record review of the nurses' progress notes dated 10/27/25 at 20:06 PM thru 01/27/26 at 19:33 PM, also recorded Resident #138 as currently and actively receiving. Oxygen two (2) liters via nasal cannula. Computerized record review also revealed Resident #138's recorded Oxygen saturation levels via nasal cannula from 12/09/25 at 14:31 PM through 03/10/26 at 05:37 AM with a range from 90% to 99%. There was no order in the Medication Administration Record (MAR), nor in the Treatment Administration Record (TAR) for Oxygen administration therapy, with parameters. A side-by-side record review and interview was conducted on 03/11/16 at 12:08 PM with Staff J, LPN, in which she acknowledged that Resident #138 was receiving Oxygen therapy administration via nasal cannula, without a current physician's order, in place. An interview was conducted on 03/11/26 at 12:12 PM with Staff F, Registered Nurse (RN)/Unit Manager (UM) for 2nd and 3rd floors, in which she acknowledged that Resident #138 was receiving Oxygen therapy administration via nasal cannula, without a current physician's order, in place. An interview was conducted on 03/11/26 at 12:17 PM with the RN/Assisted Director of Nursing (ADON)/Nurse Supervisor, in which she also acknowledged that Resident #138 was receiving Oxygen therapy administration via nasal cannula, without a current physician's order, in place. A physician's order was not obtained for Resident #138's Oxygen therapy administration, until after surveyor intervention. The DON (Director of Nursing) further recognized and acknowledged on 03/11/26 at 1:30 PM that a physician's order should have been obtained for the Oxygen Administration Therapy. 2). Record review revealed Resident #79 was admitted on [DATE] with diagnosis of Type 2 Diabetes Mellitus and Chronic Obstructive Pulmonary Disease. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that the resident's Brief Interview of Mental Status (BIMS) score is 00, which indicates that they were unable to conduct the interview due to severe cognitive impairment. A review of section O (Special treatments, Procedures and Programs) of the MDS indicated that Resident #79 was not coded for oxygen therapy on admission or while in the facility. A review of the Physician's Orders indicated that on 06/09/24 an order for oxygen concentrator with humidifier was placed in for 2 liters per minute via nasal cannula to keep oxygen saturation above 92%. A review of the care plan dated 12/25/25 documented that Resident #79 has alteration in breathing (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105298	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FT Lauderdale Health & Rehabilitation Center	2000 East Commercial Blvd Fort Lauderdale, FL 33308

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pattern related to history of Chronic Obstructive Pulmonary Disease. Goals are to maintain resident free of respiratory distress. The interventions included setting oxygen and tubing changed as ordered. In an observation conducted on 03/09/26 at 11:05 AM, Resident #79 was seen lying in bed with the oxygen in place and functioning. The oxygen was set at 4 liters per minute. In an observation conducted on 03/10/26 at 11:30 AM, Resident #79 was seen lying in bed with the oxygen in place and functioning. The oxygen was set at 4 liters per minute. In an observation conducted on 03/11/26 at 12:15 PM, Resident #79 was seen lying in bed with the oxygen in place and functioning. The oxygen was set at 4 liters per minute. In an interview conducted on 03/11/26 at 12:20 PM with Licensed Practical Nurse (LPN), Staff A stated that she has been working in the facility for less than a month. She further stated that the nurses are the ones responsible for recording the oxygen saturation. The nurses are the parties responsible for regularizing the oxygen concentrator per medical order. They also have someone from the insurance company that comes in the morning and records the vital signs. She was made aware of the oxygen saturation number set for Resident #79, and she stated that the saturations are not correct. In an interview conducted on 03/11/26 at 12:30 PM with LPN, Staff B stated that she has been working in the facility for 22 years now. She was made aware of the findings and stated that it's impossible for a resident with diagnosis of COPD to saturate 99% on room air. She explained that the nurses are the ones responsible to set the concentrator based on orders. In an observation conducted on 03/11/26 at 12:45 PM, this surveyor accompanied LPN, Staff B and LPN Staff A to Resident #79. They acknowledged that the oxygen concentrator was set at 4 liters and the order was for 2 liters. In an observation conducted on 03/11/26 at 12:47 PM, this surveyor accompanied Staff LPN, Staff B with the oxygen saturation machine and staff took the oxygen saturation of Resident #79 and at that time it was 99% with oxygen in use. Per interview Staff stated that without the oxygen the expectation is for Resident #79 to saturate less due to medical condition. She further explained that it's not possible for Resident #79 to be saturating the same amount on room air and on oxygen therapy. In an interview conducted on 03/11/26 at 2:00 PM, the Assistant Director of Nursing (ADON) stated that she has been working in the facility for less than 6 months. She further stated that setting up the concentrator and recording the oxygen saturation is done by the nurses. It would be accurate if a resident is saturating 99% on room air and 97% on oxygen therapy. The ADON was showed the photographic evidence that Resident 79's was on 4 liters when the order was 2 liters. Having oxygen at 4 liters is very damaging to the resident and eventually worsens the COPD. The insurance staff members cannot document into Point Click Care (PCC) and they have their own system. In an interview conducted on 03/11/26 at 3:30 PM, the MDS Coordinator stated that she has been working in the facility for years now. She further explained that when a Resident is on oxygen therapy it should be coded under section O. Per review of Resident #79's medical record, the Quarterly MDS dated [DATE] was not coded for receiving continuous oxygen therapy on admission and while being a resident at the facility. The MDS Coordinator acknowledged the findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105298	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FT Lauderdale Health & Rehabilitation Center	2000 East Commercial Blvd Fort Lauderdale, FL 33308

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to accurately reconcile controlled medications and failed to ensure discontinued controlled medications were removed from the medication cart for 3 of 12 sampled residents reviewed for controlled medications reconciliation, Resident #37, Resident #172 and Resident #156. The findings included: Review of the facility's policy titled, Controlled Substances, dated December 2012, included the following: The facility shall comply with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of Scheduled II and other controlled substances. 4. If the count is correct, an individual resident controlled-substance record must be made for each resident who will be receiving a controlled substance. Do not enter more than one (1) prescription per page. This record must contain: a. Name of the resident;b. Name and strength of the medication. 1. Record review for Resident #37 revealed the resident was admitted to the facility on [DATE] with a re-admission on [DATE] with diagnoses that included: Hemiplegia and Hemiparesis following Cerebrovascular Disease Affecting Left Non-Dominant Side; Type 2 Diabetes Mellitus Without Complications and Mononeuropathy. The Annual Minimum Data Set (MDS) dated [DATE] revealed Resident #37 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated she was moderate cognitively impaired. Review of the Physician's Orders showed that Resident #37 had an order dated 01/05/26 for Tramadol HCl tablet 50 mg to give 1 tablet by mouth every 8 hours (6:00 AM, 2:00 PM, and 10:00 PM) for moderate to severe pain for non-acute pain.Review of Resident #37's March 2026 Medication Administration Record (MAR) documented, Tramadol 50 mg, every 8 hours was administered on the following dates: 03/07/26 at 2200 (10:00 PM)03/08/26 at 6:00 AM03/08/26 at 1400 (2:00 PM)03/08/26 at 10:00 PM03/09/26 at 6:00 AM03/09/26 at 2:00 PM03/09/26 at 10:00 PMHowever, review of Resident #37's Medication Monitoring /Control Record revealed there was no nurse's signature or that Tramadol 50 mg was administered on 03/08/26 at 1400 (2:00 PM). 2. Record review for Resident #172 revealed the resident was admitted to the facility on [DATE] with diagnoses that included: Fracture of Unspecified Part of Neck of Right Femur, Subsequent Encounter for Closed Fracture with Routine Healing. The 5-Day MDS dated [DATE] revealed Resident #172 had a BIMS score of 11, which indicated she was moderate cognitively impaired. Review of the Physician's Orders showed that Resident #172 had an order dated 02/18/26 for Tramadol HCl tablet 50 mg to give 1 tablet by mouth every 6 hours as needed (PRN) for Acute Pain exception 7-10 (pain levels).Review of the February 2026, MAR documented Resident #172 was administered Tramadol 50 mg PRN on the following dates: 02/20/26 at 2100 (9:00 PM)02/21/26 at 10:00 AM02/22/26 at 2:42 AM02/23/26 at 4:07 AMHowever, review of Medication Monitoring /Control Record revealed Resident #172 was administered Tramadol 50 mg PRN on the following dates and time: 02/20/26 at 3:00 AM (not documented in the MAR)02/20/26 at 2100 (9:00 PM)02/21/26 at 10:00 AM, Error was written and the date and time was crossed out02/22/26 at 2:42 AM 02/23/26 at 9:53 AM 3. Record review for Resident #156 revealed the resident was admitted to the facility on [DATE] with a re-admission on [DATE] with the following diagnoses: Polyneuropathy, Type 2 Diabetes Mellitus, Gout, Pain in Unspecified Joint, and Low Back Pain. The MDS dated [DATE] revealed Resident #156 had a BIMS score of 14, which indicated she was cognitively intact. Review of the Physician's Orders showed that Resident #156 had an order dated 02/23/26 Oxycodone HCl 5 mg tablet to give 1 tablet by mouth every 8 hours PRN for severe pain level 7-10, with a discontinued date of 02/25/26.Review of the February 2026, MAR revealed Resident #156 was administered Oxycodone HCl 5 mg tablet PRN on:02/24/26 at 2:51 AM with a pain level of 6 of 10.02/24/26 at 1424 (2:24 PM) with a pain level of 6 of 10.On 02/25/26 Oxycodone HCL 5 mg was discontinued.Review of Resident #156's Medication Monitoring/Control Record documented on 03/08/26 at 5:30 AM that one tablet of Oxycodone HCL 5 mg was removed (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105298	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FT Lauderdale Health & Rehabilitation Center	2000 East Commercial Blvd Fort Lauderdale, FL 33308

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	from the locked drawer of the medication cart. Record review of the nursing progress notes revealed no documentation showing that Oxycodone 5 mg was administered to the resident on 03/08/26. In addition, there was no progress note showing communication with Resident #156's medical provider for an order to renew the medication.During an interview conducted on 03/12/26 at 4:04 PM with the Director of Nursing (DON), who stated the controlled medications that are discontinued are to be removed as soon as possible from the medication cart. She stated two nurses verify the orders for discontinued medications and bring them to her, then she double locks the controlled medication until the pharmacist comes in and then the medication is destroyed. The DON stated as per protocol the count of the controlled medications in the medication cart drawer is compared to the number in the Medication Monitoring / Control Record, and this is done every shift. When asked if anyone (unit manager/DON) randomly conducts periotic reconciliation of controlled medications, she stated, no. At this time, a side-by-side review of Resident #37, Resident #172 and Resident #156's Medication Monitoring/Control Record and their MARs were conducted with the DON. The DON acknowledged there were discrepancies between them.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105298	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FT Lauderdale Health & Rehabilitation Center	2000 East Commercial Blvd Fort Lauderdale, FL 33308

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of policy and procedure, observation, interview and record review, the facility failed to 1) ensure that it secured and locked three (3) over-the-counter (OTC) topical cream medication tubes for the sampled residents observed, Resident #138, 2) to promptly discard one (1) expired OTC topical cream medication tubes for Resident #138. 3) secure and lock the Medication cart located on the South wing, for 1 of 8 Medication carts observed, 4) properly label topical medications stored in Medication Storage rooms on the second floor for 1 of 6 Medication Storage rooms observed.The findings included:Review of the facility policy and procedure titled Storage of Medication provided by the Director of Nursing (DON) revised [DATE] documented in the Policy Statement: The facility shall store all drugs and biologicals in a safe, secure and orderly manner.2. The nursing staff shall be responsible for maintaining medication storage AND preparation areas in a clean, safe, and sanitary manner.4. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed. 7. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others. 1) Record review revealed Resident #138 was originally admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included Pneumonia, unspecified organism, Chronic Obstructive Pulmonary Disease with (acute) exacerbation, Respiratory Failure, unspecified, unspecified whether with hypoxia or hypercapnia, Spondylosis without Myelopathy or Radiculopathy, Lumbar region, Pulmonary Fibrosis, unspecified, Hypertension, Hemiplegia and Hemiparesis following Cerebral Infarction affecting Right Dominant Side and Encephalopathy, unspecified. She had a Brief Interview Mental Status (BIMS) score indicative of intact cognition. During an observational room tour conducted on [DATE] at 10:21 AM, Resident #138 was observed with three (3) different tubes of OTC (over the counter) topical cream medications left unsecured and unattended, at the resident's bed side, which included: 1) Salonpas with Lidocaine Plus 4% with an expiration date of 02/2027, for which the resident stated is applied by staff.; 2) Maximum Strength Blue Emu with 4% Lidocaine numbing pain relief cream (highest concentration without a prescription), with an expiration date of 01/2020; and 3) [NAME] anti-itch cream containing Pramoxine Hydrochlorozide 1%, Menthol 0.5% (an external analgesic lotion), with an expiration date of 02/2027. A brief interview was conducted at the time of observation, with Resident #138, in which she was asked about the topical OTC medicated creams at her bedside. She stated that they were used primarily for her hands and other dry skin areas. On [DATE] at 4:21 PM through [DATE] at 10:10 AM, Resident #138's room was observed having the same three (3) different tubes of OTC topical cream medications left unsecured and unattended, at the resident's bed side on her nightstand and on her overbed table An interview and side-by-side record review was conducted on [DATE] at 12:08 PM with Staff J, Licensed Practical Nurse (LPN), regarding the three (3) different tubes of OTC topical cream medications left unsecured and unattended, at the Resident #138's bedside on her nightstand and on her overbed table. She acknowledged that the OTC topical cream medications should not have been (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105298	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FT Lauderdale Health & Rehabilitation Center	2000 East Commercial Blvd Fort Lauderdale, FL 33308

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	left there and that the expired topical OTC cream should have been promptly discarded. During an interview conducted on [DATE] at 12:12 PM with Staff F, Registered Nurse (RN)/Unit Manager (UM) for 2nd and 3rd facility floors, in which she indicated that Resident #138 does not self-administer any of her own medications and neither was she assessed by the Interdisciplinary Team (IDT) to be able to self-administer. An interview was conducted on [DATE] at 12:17 PM with the RN/Assisted Director of Nursing (ADON)/Nurse Supervisor regarding the three (3) different tubes of OTC topical cream medications left unsecured and unattended, at the resident's bedside. She acknowledged that the OTC topical cream medications should not have been left there and the expired topical OTC cream should have been promptly discarded. 2). On [DATE] at 11:16 AM during a hallway tour, it was observed that the medication cart located on the South wing, containing medication for a total of thirty (30) residents residing on the wing, was left unlocked and attended by nursing staff, with no nursing staff in-sight; accessible to residents, staff member and visitors. An interview was conducted on [DATE] at 11:18 AM with Staff K, Licensed Practical Nurse (LPN), in which she acknowledged that the medication cart had been left unlocked and unattended. An interview was conducted on [DATE] at 11:22 AM with Staff B, LPN, Unit Manager South wing, in which she also acknowledged that the Medication cart had been left unlocked and unattended. On [DATE] at 1:30 PM the Director of Nursing (DON) further acknowledged that the OTC topical cream medications should not have been left at resident's bedside and that the expired topical OTC medication, should have been promptly discarded. She also mentioned that medication carts must always be kept locked and secure. 3). On [DATE] at 10:37 AM, a medication storage room on the second floor of the facility (rooms 201-219) was inspected with Staff F, Unit Manager. It was observed that on the bottom of a metal rack there was a blue container containing plastic bags with topical medications. Further observation revealed a few opened topical creams in plastic bags only labeled with just numbers written on the box. One of the opened medication boxes had 36B written on the box (the second floor does not have a room [ROOM NUMBER]B). Photographic evidence obtained. An interview was conducted on [DATE] at 10:41 AM with Staff F, Unit Manager, who stated she has worked at the facility for 4 years. She stated the protocol is to store residents' topical medications in the storage room and not in the medication carts. She then stated all the topical medications are labeled for the residents that are on the floor and removed once the resident is discharged . Staff F stated that she, along with the evening nurses, is responsible for ensuring the medication storage room stays current and properly maintained.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105298	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FT Lauderdale Health & Rehabilitation Center	2000 East Commercial Blvd Fort Lauderdale, FL 33308

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observations, interviews and record reviews, the facility failed to follow the approved menu for lunch on 03/11/26. The deficient practice had the potential to affect 90 residents with orders for regular texture foods. The census at the time of the survey was 161 residents. The findings included:A review of records indicated that the approved lunch menu for March 11, 2026, specified a 3-ounce serving of 'Pork Chop BBQ' for residents.During a kitchen observation conducted on March 11, 2026 at 11:27 AM, with the Food Service Director (FSD) present, it was observed that the pork that was plated to be served consisted of thinly sliced, bone-in pork chop portions. Upon request from the surveyor, the FSD weighed a portion of the plated pork, which measured 2.5 ounces including the inedible bone.The FSD acknowledged these findings at the time of observation and subsequently instructed staff to add an additional half portion of pork chop to each plate to ensure a total serving of 3 ounces of Pork Chop BBQ was provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105298	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FT Lauderdale Health & Rehabilitation Center	2000 East Commercial Blvd Fort Lauderdale, FL 33308

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 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to serve food in appropriate form to meet the needs of 1 of 43 residents with orders for mechanical soft foods, Resident #72. The findings included:Record review for Resident #72 revealed an admission date to the facility on [DATE]. According to Resident #72's most recent complete assessment, a Quarterly Minimum Data Set, with a reference date to the facility on [DATE], the resident had a Brief Interview for Mental Status score of 07, indicating the resident had severe cognitive impairment. Resident #72's diagnoses at the time of the assessment included: Non-Alzheimer's Dementia, Malnutrition, Chronic lung disease, Gastro-esophageal reflux disease (GERD). The assessment documented that the resident experienced ?complaints of pain when swallowing' during the 7-day look back period. Record review revealed Resident #72's diet orders included: Regular diet, Mechanical Soft texture, Thin consistency - 10/24/23 with a revision date of 10/31/25 Resident #72's care plan for nutrition documented:Resident is at risk for an alteration in: nutrition and/or hydration related to: receives mechanically altered diet, dementia, CAD (Coronary Artery Disease), GERD, COPD (Chronic Obstructive Pulmonary Disease), Protein/Calorie malnutrition, low BMI (Body Mass Index) with diagnoses of muscle wasting/atrophy. Date Initiated: 05/08/2023 Revision on: 02/20/2026. Interventions to the care plan included: Provide diet as ordered. Offer and provide alternate as needed Record review revealed Resident #72's care plan for dental care documented:Resident has natural teeth with some missing. Denies mouth pain or chewing problems with current diet. Date Initiated: 07/26/2025 Revision on: 08/04/2025 Interventions included: Diet as ordered. Date Initiated: 05/02/2023 During an observation of lunch served in the dining are on the first floor, on 03/09/2026 at 12:33 PM, it was noted that Resident #72 was served a hot dog that was cut into large chunks. During an interview, on 03/09/26 at 12:52 PM, with the Food Service Director, (FSD) when shown the photographic evidence of the concern, the FSD acknowledged understanding of the concern. The FSD demonstrated that the hot dog in the form that it was served was not appropriate for a resident with an order for mechanical soft food. By using a fork, the FSD was not able to push the fork completely through the skin of the hot dog. During an interview, on 03/12/26 at 2:06 PM the Speech Language Pathologist (SLP), the SLP acknowledged that the hot dog served to the resident was not appropriate, based on the photographic evidence and the demonstration by the FSD.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105298	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FT Lauderdale Health & Rehabilitation Center	2000 East Commercial Blvd Fort Lauderdale, FL 33308

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 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 observations, interviews, and record review, the facility failed to clean and disinfect the glucometer as per manufacturer's instructions and properly perform hand hygiene for 1 of 1 sampled resident reviewed for blood glucose monitoring (Resident #197). The facility also failed to implement measures for infection control practices during intravenous (IV) antibiotic therapy for 1 of 1 sampled resident reviewed for infection control (Resident #175). The findings included: Review of the facility's policy titled, Obtaining a Fingerstick Glucose Level, dated October 2011, included the following:Purpose: The purpose of this procedure is to obtain a blood sample to determine the resident's blood glucose level.Steps in the Procedure:3. Always ensure that blood glucose meters intended for reuse are cleaned and disinfected between resident uses. 18. Clean and disinfect reusable equipment between uses according to the manufacturer's instructions and current infection control standards of practice. 19. Remove gloves and discard into designated container.20. Wash hands.Review of the facility's policy titled, Cleaning and Disinfection of Glucometer Machine undated, included the following: Glucometer Machines will be cleaned and disinfected according to current CDC recommendations for disinfection and the OSHA Bloodborne pathogens standards. Policy Interpretation and Implementation:1) Glucometer machine will be cleaned and disinfect with a commercially available disinfectant (i.e. Microdot, Dispatch, Sani-cloth with orange top) that has 1:10 dilution of bleach and detergent.2) The nurse will use gloves while cleaning the glucometer machine.3) The glucometer machine will be wiped with the Bleach wipes until completely wet.4) After the glucometer machine has been wiped and left wet, it will be wrapped with the Bleach wipes towel for a total of 3 or 5 minutes depending what the manufacturers guidelines.5) When the required wet times have passed, then the nurse will wipe and dry the glucometer and ready for use for another resident. 1. Record review for Resident #197 revealed the resident was admitted to the facility on [DATE] with diagnoses that included: Type 2 Diabetes Mellitus without Complications, and Chronic Obstructive Pulmonary Disease. The Minimum Data Set (MDS) dated [DATE] revealed Resident #197 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated that she was cognitively intact.Review of the Physician's Orders showed Resident #197 had an order dated 03/05/26 for Novolin R. (insulin) Flex Pen 100 UNIT/ML Solution pen-injector (Inject as per sliding scale: if 150 - 200 = 2 unit; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units Greater than 400 =12 Units AND Call MD For Hyperglycemia) to inject subcutaneously before meals and at bedtime.During an Accu-Chek observation conducted on 03/11/26 at 11:38 AM with Staff C, Registered Nurse (RN), who stated she was ready to check the blood glucose level for Resident #197 and the Glucometer was cleaned. On a foam tray, she had prepared the Glucometer, 2 lancets, alcohol wipes and 2 test strips. Staff C, RN, locked the medication cart, grabbed the foam tray and entered the room. Then grabbed a pair of gloves from the wall and put them on (no hand hygiene was conducted); with the gloves on she used the bed remote to raise the head of the bed for Resident #197, then inserted the test strip into the Glucometer still wearing the same gloves. Staff C, RN, performed the blood glucose level test and then gathered all the sharps in a cup and discarded her gloves. Without washing her hands, she exited Resident #197's room and placed the Glucometer and the cup (containing sharps) on top of the medication cart. She then asked the surveyor how she did, and at this time she was asked if she had used hand sanitizer during the procedure. Then she used the hand sanitizer and put the sharps in the sharp container; grabbed the Glucometer and stored it in the top drawer of the medication cart (without disinfecting it). During an interview conducted on 03/11/26 at 11:45 AM with Staff C, RN, who stated she has worked at the facility for one month. She was asked when she would clean the Glucometer after using it on a resident. She stated that she has a few more residents to check the blood glucose levels, she cleans the Glucometer then. At this time, Staff C removed the Glucometers (there was another Glucometer in the drawer) out of the drawer and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105298	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FT Lauderdale Health & Rehabilitation Center	2000 East Commercial Blvd Fort Lauderdale, FL 33308

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	placed them on top of the medication cart. Then she stated she does not have the wipes in the cart to clean the Glucometers. An interview was conducted on 03/11/26 at 12:04 PM with the Director of Nursing (DON) and was made aware of the above concerns. 2. Record review for Resident #175 revealed the resident was admitted to the facility on [DATE] with a re-admission date on 03/04/26 with diagnoses that included: Cerebral Infarction, Bacteremia, Pneumonitis Due To Inhalation of Food and Vomit. The Quarterly MDS dated [DATE] revealed Resident #175 had a BIMS score of 08, which indicated that she was moderately cognitive impaired.Review of the Physician's Orders showed Resident #175 had an order dated 03/06/26 for Vancomycin HCl (antibiotic) Intravenous (IV) Solution Reconstituted 1 GM, to use 1 gram intravenously one time a day every other day for Staph epimeriids bacteremia until 03/18/26.On 03/12/2026 at 9:29 AM an IV medication administration observation was conducted with Staff D, RN for Resident #175. She stated she has worked at the facility for 3 months. She washed her hands, don on Personal Protective Equipment (PPE), including a gown (which she did not tide behind her waist and the tides of the gown were dragging on the hallway floor), and gloves. She entered the room with the IV medication bag, IV tubing and the gown untied. Staff D stated she would check Resident #175's IV site then stated she would prime the tubing (the process to remove air in the tube) and tide her gown at the waist. As she was trying to spike the IV medication bag, she dropped the tubing and the IV medication bag on the floor. She picked up the tubing and threw it away, then picked up the IV medication bag (without wiping it down) removed her PPE, washed her hands and she and the surveyor exited the room. Staff D went to the storage medication room holding the IV medication bag. She then returned to the medication cart which was located by Resident #175's room; washed her hands and don on PPE, then entered the room holding the IV tubing and the dirty IV medication bag with her gloved hands. She again struggled to spike the IV medication bag but finally was able to prime the IV tubing. She walked to the IV pole and hung the medication bag. Without changing her gloves, she started to get the IV tubing into the machine touching the IV tubing and holding the IV connector (Clave) with her left gloved hand. Finally, Staff D, RN, was able to connect the IV tubing with the machine; then used an alcohol wipe to clean the IV tubing Clave (which now she was holding with her right hand) and used another alcohol wipe to clean the resident's IV connector. Staff D, RN, stated she needed another alcohol wipe, she let go of the resident's IV connector and reached for another alcohol wipe to clean the IV tubing Clave but not the resident's IV connection. She then opened the IV tubing to allow the medication to flow and stated she would stay with Resident #175 for 5 minutes to ensure no infiltration. She was then asked if she felt she followed Infection Control protocol and she stated yes. On 03/12/26 at 12:10 PM the above concerns were discussed with the DON and the Infection Preventionist.