STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105371	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Johns Nursing Center	3075 NW 35th Ave Lauderdale Lakes, FL 33311

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to follow the facility policy of documenting identified changes in the sacral skin condition for 1 of 1 sampled resident reviewed for pressure ulcers, Resident #1.The findings included:Review of facility's policy, titled, Wound Prevention, Skin Observation, with an effective date of 10/19/05, and a revision date of 11/21/17, documented that 'the nurse would evaluate and document identified changes in the weekly skin check section of the electronic medical record.' Record review documented Resident #1 was admitted to the facility on [DATE] after a surgical operation of the right knee. The resident had history of Vancomycin induced Acute Kidney Injury, Atrial Fibrillation and Hypertension. The resident was discharged to a hospital on [DATE]. Review of the admission Minimum Data Set (MDS) assessment, dated 02/02/26, documented Resident #1 had a Brief Interview for Mental Status (BIMS) score of 14 indicating he had good cognitive function.Section M revealed a presence of one Stage I pressure ulcer or injury. Review of nursing progress notes, dated 01/27 26 at 9:35 PM and on 01/28/26 at 10:11 AM, documented Resident #1 had redness and/or sacral rashes with no signs and symptoms of infection noted. The notes added that the sacral rashes were present on admission. After 01/28/26, there were no further nursing progress notes about the redness or sacral rashes. The daily general skin assessment documented the skin was warm and dry, with several documentations regarding the right knee surgical site skin conditions on these dates: 02/09/26, 02/03/26, 02/02/26, 01/28/26, and 01/27/26. In an interview conducted with Staff A, Certified Nursing Assistant (CNA) on 02/12/26 at approximately 11:13 AM, she was asked their process of admitting new resident. She responded they help the resident in the room and perform skin assessment with the nurses. Staff A stated the nurses document all the findings, and they both agreed that if there are skin conditions they must be reported to the doctor. She stated she continually performs skin assessments when she performs daily care to the resident and then reports to the nurse if there are new skin conditions observed or if the former skin condition is worsening. In an interview conducted with Staff B, Registered Nurse, on 02/12/26 at 12:43 PM, when she was asked her admission process, she responded that she and the assigned CNA perform the head-to-toe assessment to ensure all skin areas are assessed. She takes notes of any redness, or open skin areas, notifies the doctor and documents all her findings in the progress notes. Staff B added that the staff performed weekly skin assessment for Resident #1 to makes sure the redness in the sacral area was improving. She stated she remembered applying cream to that area. When she was asked if she monitored and measured the sacral redness / rashes after the initial admission assessment, she responded, no. She stated she did not monitor or measure the area because the wound care nurse does the monitoring and measuring. Staff B stated the wound care nurse documented all the skin conditions for the resident after the staff nurses make the skin referral. In an interview conducted with Staff D, Wound Care Nurse on 02/12/26 at approximately 11:26 AM when asked if she assessed and monitored (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
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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the sacral area with redness/rashes for Resident #1, she responded that she saw it on admission, a cream was ordered by the physician, and the nurses applied the cream daily as ordered. Staff D stated, the resident was in a 'turning every 2 hours program', but no, she did not monitor the sacral area, and only monitored and documented updates regarding Resident #1's right knee surgical area. She stated she thought the staff nurses were monitoring and documenting the sacral area redness and rashes.In continuing interviews with the nurses, they stated that skin conditions are documented upon admission, and weekly thereafter, but when they were asked to provide the documentation for Resident #1, they stated they did not document the weekly skin assessment of the sacral area. They stated they thought the Wound Care Nurse is responsible for the weekly documentation of the sacral area for Resident #1. Review of Resident #1's nursing care plan revealed the sacral area would show evidence of healing by 02/13/26. The interventions revealed to monitor, measure and document wound status on a weekly basis until healed. Additional record reviews revealed no documentation in the nursing progress notes regarding monitoring, measuring, and documenting the wound status on a weekly basis. In an interview conducted with the Assistant Director of Nursing (ADON) at approximately 4:30 PM, when informed that staff nurses thought that only the Wound Care Nurse was documenting, measuring and monitoring Resident #1's sacral area, she responded that all staff nurses received Health Stream (the facility's online continuing education flatform) training regarding documentation of pressure ulcers. She did not understand why the facility nurses were not documenting according to the training and their policy.