STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105550	A. Building B. Wing	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookwood Gardens Rehabilitation and Nursing Cente	1990 S Canal Drive Homestead, FL 33035

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 - 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 observation, interview, and record review, it was determined that the facility failed to ensure procedures and safety measures were in place for the temperature and serving of hot beverages for one (Resident #1) of three residents reviewed. Staff served hot coffee without checking the temperature to Resident #1, an individual with upper extremity weakness who was left unsupervised. Subsequently, the coffee was spilled, resulting in Resident #1 sustaining third-degree (full thickness) burns on the abdomen, left hip, and right lower back. This incident led to a notable level of harm. The findings included: Observation on 05/14/2026 at 7:08 AM Resident #1 was noted in bed with eyes closed no distress noted.Review of the facility's policy titled: Accident and Incident Prevention, Reporting, and Response. Dated 07/2025 and Reviewed 05/05/2026 included:PurposeTo ensure a safe environment for all residents by minimizing accident hazards, providing adequate supervision and assistive devices, and implementing a proactive and systematic approach to preventing, investigating, and mitigating accidents and incidents in accordance with federal regulations (F689), facility policies, and resident-centered care principles.Policy StatementThe facility is committed to: Maintaining a resident environment that is as free as possible from accident hazards while meeting individual resident needs. Ensuring adequate supervision and appropriate use of assistive devices to reduce the risk of accidents and incidents. Promptly identifying, reporting, documenting, investigating, and mitigating all incidents or accidents involving residents.Definitions Accident: An unexpected, unintended event that results in or has the potential to result in injury, harm, or adverse change in a resident's condition. Incident: Any event, occurrence, or situation that is not consistent with the routine operation of the facility or the routine care of a resident, regardless of whether it results in injury. Record review of the facility's policy titled Hot Beverage Safety dated 5/2026 included:PolicyThis center's policy outlines procedures for the safe preparation, distribution, and consumption of hot beverages to help ensure the safety of residents and staff by minimizing the risk of burns or scalding from hot beverages, such as coffee, soups, and teas.Background:The mouth has protective mechanisms that can reduce the risk of injury from hot beverages. Saliva's mechanism is to cool a hot beverage during consumption. The very rapid blood flow in the mucosa in the mouth carries away some heat. The lips and tongue are sensitive and help take in hot beverages only as fast as the mouth can cool the beverages. Skin on the arms and legs is less sensitive than the skin on the mouth and can be burned before the danger is realized. Clothes may hold a hot beverage spill against the skin, increasing the risk of injury in a shorter amount of time.Procedure: A. Beverage Temperature Standards - When NOT coming directly from the kitchen: 1. All hot beverages served to residents must be at or below 120 F (48.9 C). 2. Staff (nurse or CNA) must use a calibrated food thermometer to verify beverage temperatures prior to serving when the beverage is not coming from the kitchen. 3. Any beverages exceeding 120 F must be allowed to cool before service. 4. Reheating liquids/soups in a microwave a., when possible, reheat at 70% power instead of 100%. c. At the end of the heating, let the food/beverage stand for one minute. e. Do not serve the resident until the internal temperature is 120 degrees or less. f. Staff (nurse or CNA) must take the temperature of the beverage/soup prior to (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	delivering to the resident. The temperature cannot exceed 120 degrees Fahrenheit prior to delivery. On 06/10/2026 the coffee temperatures checked with a digital thermometer revealed:South dining area coffee temperature for lunch: 132.1 degrees Fahrenheit.North Side coffee temperature for lunch: 140.3 degrees Fahrenheit.East Side coffee temperature for lunch: 128.2 degrees Fahrenheit.South dining area coffee temperature for dinner: 124.6 degrees Fahrenheit. Record review of the incident description documented: At approximately 2:30 AM, the resident requested a CNA (Certified Nursing Assistant) to prepare instant coffee. The CNA heated approximately 16 oz (ounces) of water in a foam cup in the microwave for about 2 minutes. Instant coffee was mixed, covered with a lid, and placed on the resident's bedside table, which was positioned over his abdomen. The resident then requested privacy, and the CNA exited the room. Shortly afterward, around one minute, the resident activated the call light. Upon returning, the CNA observed that the resident had spilled hot coffee onto his abdomen. The CNA immediately notified the assigned nurse. Resident was noted to be wearing a t-shirt and covered with a blanket (per CNA report); gown was grabbed by CNA to clean the coffee, which was promptly removed. Skin assessment revealed erythema extending from the mid-abdomen to the right flank, with some areas of blistering. The physician was notified, and treatment was initiated with Silvadene (silver sulfadiazine).Review of the facility's incident Summary indicated: The resident sustained a thermal burn to the abdomen/right flank after spilling hot coffee. Immediate nursing intervention and physician notification were completed, and appropriate treatment was initiated. Contributing factors may include the high temperature of the liquid, resident behavior, and positioning of the beverage. Incident reviewed for adverse - not considered adverse as the patient did not go to a higher level of care and the plan of care was being followed as resident was set up only for meals. No abuse/neglect suspected.Review of Health Status Note Effective Date: 04/22/2026 time stamped 02:37 (2:37 AM) completed by Staff D, Registered Nurse (RN) noted: At approximately 2:30 AM, resident requested a hot coffee beverage, which was provided by CNA (Certified Nursing Assistant) as requested. Resident was positioned in high Fowler's position, and the coffee cup was placed on the bedside table within reach. Resident was alert and oriented x (times) 4 and stated he would manage the drink independently, beginning to sip coffee and requesting CNA to leave the room. While exiting, CNA was called back by the resident. Upon re-entry, CNA observed that the resident had spilled hot coffee on himself. At the time, the resident was wearing a hospital gown and was covered with a blanket. CNA immediately notified this nurse. Gown and blanket were removed promptly, and assessment revealed a superficial blister with surrounding erythema to the right lower back area. Cold water compresses were applied to the affected site, followed by Silvadene cream and coverage with a non-adherent dressing. PRN (as needed) Acetaminophen was administered for pain as ordered, with noted relief. When questioned, resident reported that the coffee cup slipped from his hands while drinking. Staff J, ARNP [Advanced Registered Nurse Practitioner] was notified, and new wound care orders were received and implemented as directed. Vital signs were obtained following the incident and were stable within normal limits. No abnormal behaviors noted. Resident's emergency contact was also notified of the incident. Will continue to monitor closely. The patient was evaluated by the wound care team today following a request from the floor nurse and supervisor. During a head-to-toe assessment erythema (redness) was observed on the abdomen, measuring 34.4 x 14.7 x nm, with a small fluid-filled blister noted. Treatment: Apply Silver Sulfadiazine cream daily and as needed, leaving the area open to air. The patient received education on skin and wound care each day. Patient demonstrated understanding asked for Social Services. and [Staff H] Social Services agent was notified. Staff J, APRN (Advanced Practice Registered Nurse) was notified.Review of the Skin/Wound note dated 04/22/2026 at 13:20 (1:20 PM), completed by Staff L, RN, documented that the resident's family member was contacted by telephone and provided with care plan information and updates regarding the Resident #1's newly identified skin condition.Review of the Risk Manager Comments dated 04/29/2026 documented: Around 2:30 AM, resident requested a hot coffee beverage, which was provided by CNA. Resident was positioned in high Fowler's position, and the coffee cup was placed on (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	the bedside table within reach. Resident alert and oriented x4. Then resident called CNA to report that he spilled the coffee on top of his abdomen. CNA immediately reported to nurse and assessment was completed, resident noted with redness are to abdomen. Treatment initiated. W/C (Wound Care) evaluation and treatment in place. Plan of care reviewed. OT (Occupational Therapy) order for special cup (spill proof). All belongings arranged to right side to promote easy accesses due to left side hemiplegia. W/C Doctor evaluation. MD (Medical Doctor) and responsible party notified. Upon investigation resident stated he was trying to put the coffee back to the table and the cup slides from table. Table was within easy reach. Call light next to resident bed in good working condition, HOB (Head of Bed) elevated . Review of Resident #1's clinical records revealed the resident was admitted to the facility on [DATE] with diagnoses, including but not limited to unspecified cerebral infarction, non-traumatic intracerebral hemorrhage in the hemispheres, cortical hemiplegia and hemiparesis following cerebral infarction affecting the left dominant side, difficulty walking, muscle weakness, oral phase dysphasia, and unspecified insomnia. Resident #1 was discharged to home on [DATE]. Review of Resident #1's admission Minimum Data Set (MDS) dated [DATE] Cognitive Section indicated the resident is cognitively intact. Functional and Activities of Daily Living (ADLs) Sections documented that the resident has impairment affecting one side of both upper and lower extremities. Partial to moderate assistance is required for oral hygiene, supervision and minimal physical support are needed for eating, and substantial to maximal assistance is necessary for toileting hygiene, bathing, upper body dressing, and personal hygiene. Resident #1 is dependent on staff for footwear management and lower body dressing. Bowel and bladder records show occasional incontinence, and the resident is not enrolled in a bowel or urinary training program. Health Conditions Section noted the resident receives both scheduled and as-needed pain medication, occasionally experiencing pain levels up to 7 out of 10, and has sustained one fall without major injury since admission. The Skin Conditions section notes risk for pressure ulcers, though none are present, with preventative measures including a turning schedule. The Special Treatments section confirms receipt of physical, occupational, speech-language, and respiratory therapies, in addition to oxygen therapy. A review of Resident #1's care plans initiated on 04/04/2026 indicated the resident is at risk for impaired skin integrity due to fragile skin and incontinence. The goals specify that the resident will maintain or achieve clean and intact skin by next review date. Interventions included ensuring skin remains clean and dry; applying lotion to areas of dryness; exercising caution during transfers and bed mobility to prevent contact with sharp or hard surfaces; educating the resident, family, and caregivers regarding contributing factors and preventative measures; and adhering to facility protocols for injury treatment. During an interview on 05/14/2026 at 6:55 AM, Staff A, RN, stated that following the incident involving Resident #1, thermometers were placed in the pantry to check the temperature of hot liquids after microwaving. Liquids should not exceed 120 degrees before being served to residents. Observation on 5/14/2026 starting at 7:01 AM revealed thermometers with instructions were in all three pantries. During an interview on 05/14/2026 at 8:05 AM, the Director of Nursing (DON)revealed she was on vacation at the time of the incident and upon her return she was informed that on 04/22/2026 at around 2:00 AM Resident #1 asked for coffee the CNA brought the coffee and placed it on the overbed side table on top of his abdomen he asked for privacy and she stepped out of the room and as soon as she stepped out he put the light on and then she went back to the room she noticed he had spilled the coffee on himself. The DON stated that the investigation revealed he had tried to put back the coffee on the table and it spilled. He has instant coffee in in his room so the staff would get the hot water and prepare it. After the incident a thermometer was placed in all the pantries, and the CNAs now know how to check the temperature before. The Director of Nursing was asked if this incident could have been avoided and reported. The DON revealed the incident was not reported and was the decision made by the previous Administrator/Risk Manager. On 05/14/2026 at 11:12 AM the Assistant Director of Nursing (ADON)/East Supervisor revealed that upon her arrival in the facility on 4/22/2026 at around 7:30 AM: The supervisor told me she received report from the night supervisor (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	after the incident training for hot beverage was received and the facility's protocol for heating up any drinks, including coffee is to heat up to no more than 120 degrees Fahrenheit.On 05/14/2026 at 3:35 PM, an interview with the Chief Nursing Officer and Director of Nursing revealed that, following the incident, corrective measures were taken to prevent recurrence. These actions included risk assessments, placement of thermometers in every microwave area, staff training to check for proper temperatures, and the development and implementation of a hot beverage/liquid policy and trainings are ongoing.During an interview on 05/14/2026 at 3:55 PM Staff D, Registered Nurse 11:00 PM to 7:00 PM shift stated: When heating coffee or drinks, the staff needs to check the liquid with the thermometer that is now located in the pantry. The temperature should not exceed 120 degrees Fahrenheit. I recalled when the CNA informed me that the coffee had spilled on [Resident #1] and when I entered the room, I saw redness and a small blister on his abdomen. I immediately called the doctor and informed the family. The CNA informed me that she had provided hot water and instant coffee at his bedside because [Resident # 1 wanted to mix it on his own. I believe this incident could have been prevented. The CNA Should have asked me first or she could have assisted him. On 06/10/2026 at 12:10 PM during a telephone interview the previous Administrator revealed the incident was not reported at the time of the nursing assessment because they determined it was caused by the resident. My primary concern was ensuring that we had a policy regarding any hot items after certain hours of the day. Communication from the ADON (Assistant Director of Nursing) and regional team indicated that the incident did not require immediate action, as it was caused by the resident and the burn was not severe or high risk enough to send the resident to the hospital. For an incident to be classified as adverse, there must be evidence of intentional harm. In this case, the wound did not appear excessive or caused by another party; therefore, I believed reporting was unnecessary. The resident requested coffee, which is part of his routine. When I was there, we had a few residents who would get late night coffee. When asked if the incident could have been avoided the previous Administrator stated that from a professional perspective, he would have to say no, as there was no existing policy at the time that could have prevented the situation or provided additional supervision. However, it is possible that the incident might have been avoided if such a policy had been in place.On 06/10/2026 at 12:15 PM Staff N, RN stated: If a resident asks for coffee to heated or reheated, we need to make sure to check the temperature before serving it. The temperature should be no more than 120 degrees Fahrenheit. We have a thermometer in each pantry of the facility.During an interview on 06/10/2026 at 12:58 PM, the Dietary Manager explained that the dietary staff played a role in providing hot liquids, such as coffee, tea, and hot water. When coffee and hot water came out of the pot in the kitchen, staff poured them into the urns and kept the top or cover off until the temperature reached 140 degrees. Once the urns reached the proper temperature, they left the kitchen, and the staff on the floor took responsibility for serving the coffee at a temperature no higher than 120 degrees. The kitchen provided hot coffee during the daytime three times a day with every meal cart and the kitchen does not leave hot coffee nor water after the kitchen is closed overnight for residents. During an interview on 06/10/2026 at 1:46 PM the Social Services Director stated: I did not know about the incident until after I returned to work. I regularly visited the resident and always asked about any issues or concerns at that time, the resident did not mention any issues or concerns related to the incident. I only learned about the injury after a clinical review. I believed the incident happened over the weekend when I was not present. As the Social Services Director, I believed I should have received notification ahead of time or at the point when the incident occurred and I should have received immediate notification about any issue involving abuse, neglect. In this case, the resident requested coffee, which staff brought to him. He said that the coffee was not hot enough and asked for it to be reheated, and staff fulfilled his request. Some of the coffee spilled on him and caused burns. When asked if the incident could have been avoided, the Social Services Director stated: I believe if a policy had existed, perhaps the incident could have been prevented, especially considering his cognition. Both cognition and policy play roles. Given that abuse and neglect weren't (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Non-Pressure Full Thickness Wound: Improvement shown by reduced surface area. Surgical debridement and fluorescence imaging performed today. The wound was cleaned and numbed with a topical anesthetic. Using a sterile blade, unhealthy tissue removed from the wound. After the procedure, only healthy tissue remained, and bleeding was controlled and clean dressing applied. Primary Dressing: Silver Sulfadiazine 1% applied three times weekly and as needed for 28 days. Secondary Dressing: Gauze Island with Border used three times weekly and as needed for 28 days.Site 2 - Right Lower Back, Non-Pressure Full Thickness Wound. Surface area decreased; autolytic debridement ongoing. Fluorescence imaging performed today. Continue same dressing protocol as Site 1 for 28 days. Target: 8% wound surface area reduction. Review of the Wound Specialty Physician's evaluation signed by the Wound Care MD on 05/05/2026 at 10:31 AM shows: Abdomen non-pressure wound (Site 1), full thickness, cause undetermined, resolved as of 05/05/2026 after more than 8 days. The wound is now epithelialized and requires follow-up only if needed. Focused Wound Exam (Site 2): Right lower back non-pressure wound-full thickness, etiology unknown. Duration: over 8 days. Status: resolved as of 5/5/2026; area is now epithelialized. Follow-up only if needed. During an interview on 06/10/2026 at 6:52 PM the Wound Specialty Doctor stated: When I assessed the resident, I documented as undetermined etiology. The wound was on the abdomen and right lower back. I did not assess the resident right away. it was a couple of days later. He did not need any other interventions at the time of my assessment. I documented it was unknown etiology because I did not know how it happened.

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Brookwood Gardens Rehabilitation and Nursing Cente	1990 S Canal Drive Homestead, FL 33035

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. Based on observations, records reviewed and interviews the facility's staff did not properly label and securely store medications and biologicals on two of five medication carts (South Cart 300 and East Cart 500). Specifically, medications and supplies were left unsecured on the unattended South Medication Cart 300. This deficiency elevated the risk to resident safety. Additionally, no open date was recorded on the vial of glucometer test strips located inside East Cart 500. The findings included: Observation on 05/14/2026 at 6:25 AM, Staff A, RN, left the South Cart 300 medication cart unlocked and unattended at the nurses' station while administering medications to a resident in their room. On top of the unattended cart were two cups containing medications—one cup with a single Lyrica capsule, and another cup containing one white tablet identified as Oxycodone and one Lyrica capsule—as well as lancets and test strips. Staff A returned to the cart at 6:38 AM. During this interval, several individuals passed through the hallway. Photo evidence Review of the facility's Medication Storage Policy with reviewed date 02/16/2026 indicated: Drugs and biologicals should be stored in a safe, secure, and orderly manner. Policy Interpretation and Implementation ,6. Compartments containing drugs and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended. (Compartments include, but are not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.) 7. Drugs are stored in an orderly manner in cabinets, drawers, or carts. These compartments are of sufficient size to prevent crowding. Each resident is assigned a cubicle or drawer to prevent the possibility of a drug for one resident being given to another resident. 9.All controlled drugs are stored under double-lock and key. During an interview on 05/14/2026 at 6:46 AM Staff A, RN stated that she should have locked the cart and put the medications away the supervisor was present during this conversation with the nurse and stated that medication should never be left unattended and the cart should never be left unlocked for resident safety because anyone could have taken the medications. On 05/14/2025 at 6:58 AM, during a medication storage check with staff A, Licensed Practical Nurse (LPN) on the East side (Cart #500), a glucometer test trip vial was located inside the cart drawer with no open date written on vial (photo evidence). When Staff A, LPN, was asked about the expiration date, he stated: I was not the one who opened the glucose test strips vial, so I do not know when it was opened. Interview with Staff A, Licensed Practical Nurse (LPN) on 05/14/2026 timestamped 6:58 AM revealed when asked regarding the expiration for the glucose test strips, he stated: I received the medication cart in the morning but only checked the glucose test strip manufacturer's expiration date. I did not realize the opened date was not written on the vial. The facility's policy is to date the glucose test strip vial once it is opened because it can only be used for up to one month after someone opens it.