

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105572	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2025
NAME OF PROVIDER OR SUPPLIER Pompano Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 51 W Sample Road Pompano Beach, FL 33064	
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. (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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to ensure a physician order for a special study was scheduled and completed in a timely manner for 1 of 3 sampled resident reviewed, Resident #1. The findings included: Review of Resident #1's clinical record revealed an admission to the facility on [DATE] and a readmission on [DATE]. The resident's diagnoses included Dysphagia, Oropharyngeal Phase, Traumatic Hemorrhage of Cerebrum and Gastrostomy Status. Review of Resident #1's Minimum Data Set (MDS) quarterly assessment dated [DATE] documented a Brief Interview Mental Status (BIMS) score of 04 indicating severe cognition impairment and that the resident had a feeding tube. The resident's care plan titled Tube Feeding documented, The resident is receiving enteral nutrition r/t (related to) gastrostomy status and Dysphagia initiated on 05/10/25 with interventions to include obtain and review lab (laboratories) / diagnostic work as ordered, report results to MD [physician] and follow up as indicated. Review of Resident #1's clinical record documented a physician order dated 07/29/25 for a MBSS (Modified Barium Swallow Study) to determine the function of the oropharyngeal phase of the swallow function. Further record revealed the lack of the MBSS results on file. Review of the following Speech Therapy (ST) visits documented the following: -Date 08/06/25- .SLP (Speech Language Pathologist) completed pt's (patient's) oral care and proceeded with trials of crushed ice 1/4 to 1/2 teaspoonful boluses. Pt tolerated 17/20 boluses when provided faded verbal prompts to occasionally clear throat. -Date 08/10/25- .SLP provided pt's oral care. Pt tolerated 21 1/2 teaspoonful boluses of ice chips via guided bolus placement with efficient swallow trigger and no overt s/s (sign or symptoms) of aspiration and/or penetration. -Date 08/16/25- .SLP completed oral care and presented pt with trials of crushed ice. Pt tolerated 17 p.o. (orally) boluses of 1/4 teaspoonful of ice. Pt demonstrated no overt s/s of aspiration and/or penetration. -Date 08/20/25- .SLP completed oral care. Facilitation of Frazier free water protocol. Pt tolerated 2 oz of thin liquid water w/o (without) any overt s/s of aspiration and/or penetration. -Date 08/23/25- .ST services targeting conversational intelligibility. Patient is able to converse at 80% of the conversation. Review of Resident #1's Certified Nursing Assistant Plan of Care (POC) task response related to behavior from 07/30/25 to 08/27/25 documented no behaviors reported. On 08/27/25 at 12:32 PM, an interview was conducted with Resident #1 who stated she was in the facility for four (4) months, and she was ready to go home. The resident stated something happened to my stomach, she was crippled and could not walk. The resident added that she couldn't eat, was very hungry, couldn't drink and was very thirsty. The resident was asked if she was getting tube feeding and stated she did not want it because it makes her sick and vomit. The resident stated she was not getting water and was dying of thirsty. Resident #1 stated she asked for ice chips, they don't bother to respond, they are not together, the doctor said she is dehydrated, and they would not give her water. During the interview, observation revealed the resident had a dressing over her trachea area, a basin next to the resident with no vomiting noted, and the resident's tongue was slightly dry. On 08/27/25 at 12:38 PM, an interview was conducted with Staff A, Licensed Practical Nurse (LPN), who stated the last time the Speech Therapist saw Resident #1 she was going to start her on pleasure food. Staff A stated the resident was NPO (nothing by mouth) and could not have ice chips. On 08/27/25 at 1:32 PM, an interview was conducted with the Rehabilitation Director who stated Resident #1 was out of it when she came in to the facility, now she is more alert and asking for water and food, but her swallowing is profound, and the water and food will go to her lungs as per the Speech Language Pathologist (SLP). The Rehabilitation Director stated the resident was currently receiving ST (speech therapy). On 08/27/25 at 3:15 PM, a joint interview with the Rehabilitation Director and Staff B, SLP, was conducted. Staff B stated she was waiting for Resident #1's MBSS [Modified Barium Swallow Study] results, added she spoke to the nurse recently who asked for when they can give her ice chips and told her she was waiting for the test results. Staff B stated she did a thermal / tactile stimulation and did not hear any wet vocal quality, the time of her swallow trigger was very quick, meaning that they progress to ice chips, for trial. Staff B stated she had Resident #1 brush her teeth, the Frazier free water protocol, she cleaned in her checks with a sponge and under her lips and gave her ice chips; the resident tolerated that well. Staff B stated the Frazier free water protocol is a safe way to test that would not cause pneumonia. The Rehabilitation Director was asked how long it takes to scheduled and get an MBSS done and stated the therapy department give the referral to nursing and nursing do the scheduling, added that therapy did not schedule the study. During the joint interview, the Director and Staff B were apprised that the referral for the</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to maintain the residents' medical records that are accurately documented in accordance with accepted professional standards and practices for 1 of 3 sampled resident reviewed, Resident #1. The findings included: Review of Resident #1's clinical record revealed an admission to the facility on [DATE] and a readmission on [DATE]. The resident's diagnoses included Traumatic Hemorrhage of Cerebrum, Obstructive and Reflux Uropathy, Unspecified. Review of Resident #1's Minimum Data Set (MDS) quarterly assessment dated [DATE] documented a Brief Interview Mental Status (BIMS) score of 04 indicating severe cognition impairment. Review of Resident #1's clinical record documented a physician order dated 08/06/25 for remove foley catheter. Review of Resident #1's clinical record August 2025 Treatment administration Record (TAR) documented a foley catheter was removed on 08/07/25. On 08/28/25 at 9:21 AM, an interview was conducted with the Director of Nursing (DON) who stated that a Urology Nurse Practitioner (NP) comes to the facility every week to see residents on consultation basis. On 08/28/25 at 11:15 AM, a joint interview was conducted with the facility's Urology Nurse Practitioner (NP) and the Director of Nursing (DON). The NP stated he has been coming to facility for three (3) months, gets a consult from the facility nurses or the in-house NP. The NP was asked if he contacted the resident's family / representative to discuss the plan of care and responded if the patient/resident is alert, he will talk with the resident, will talk to the nurse, and will get a hold a family member if needed. The NP was asked if he get in touch with resident representative, especially those with a BIMS score of 4. The NP replied he never communicated with Resident #1's family / representative, did not talk to the family/representative related to a right kidney mass revealed on ultrasound done on 08/05/25. The NP stated it is important to communicate with the resident's family / representative. A side-by-side review of Resident #1's Urology-NP consult notes was conducted for the following notes:-Service date 06/24/25 documents .sex: female. Genitourinary: External Genitalia: foley catheter; Penis: normal, no lesions, no discharge; Scrotum: normal, no swelling, no tenderness; Testes: descended bilaterally, no masses, no tenderness; Spermatic Cord: no varicocele, no tenderness. Current assessment and plan discussed with patient and nursing staff.-Service date 07/22/25 documents .sex: female. Genitourinary: External Genitalia: foley catheter; Penis: normal, no lesions, no discharge; Scrotum: normal, no swelling, no tenderness; Testes: descended bilaterally, no masses, no tenderness; Spermatic Cord: no varicocele, no tenderness. Current assessment and plan discussed with patient and nursing staff.-Service date 07/30/25 documents .sex: female. Genitourinary: External Genitalia: foley catheter; Penis: normal, no lesions, no discharge; Scrotum: normal, no swelling, no tenderness; Testes: descended bilaterally, no masses, no tenderness; Spermatic Cord: no varicocele, no tenderness. Current assessment and plan discussed with patient and nursing staff.-Service date 08/05/25 documents .sex: female. GU (Genitourinary) + obstructive uropathy. Genitourinary: External Genitalia: Penis: normal, no lesions, no discharge; Scrotum: normal, no swelling, no tenderness; Testes: descended bilaterally, no masses, no tenderness; Spermatic Cord: no varicocele, no tenderness. assessment: unspecified urinary incontinence. Current assessment and plan discussed with patient and nursing staff.-Service date 08/13/25 documents .sex: female. foley catheter was removed. patient remains incontinent. GU: + foley catheter. Genitourinary: External Genitalia: Penis: normal, no lesions, no discharge, + foley catheter; Scrotum: normal, no swelling, no tenderness; Testes: descended bilaterally, no masses, no tenderness; Spermatic Cord: no varicocele, no tenderness. Current assessment and plan discussed with patient and nursing staff. During the review, the NP confirmed Resident #1 was a female and that external genitalia male information should have to be removed. The NP was apprised that his note dated 08/13/25 documented + foley catheter when the resident catheter was removed on 08/07/25.</p>		