STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105572	A. Building B. Wing	10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pompano Health and Rehabilitation Center	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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and staff interviews, the facility failed to keep food safety requirements in accordance with the professional standard of food service safety 2 visits to the main kitchen. The findings included: In a tour of the main kitchen conducted on 09/29/25 at 9:30 AM, the following issues were noted: a. The sanitation solution was checked in the 3-compartment sinks, which showed that the solution was between 400 and 500 parts per million. Using a facility's Hydrion strip, it was revealed that there was too much sanitizing solution and it was not within the normal ranges of sanitizers, which typically fall between 100 and 400, with a recommended range closer to 200. b. The reach in the freezer was noted with four containers of ice cream cups that were melted and partially opened. c. The back of the reach-in freezer was noted with debris, plastic containers, and napkins. d. Insects were noted in all stages of life, on the walls and the floor of the main kitchen. In this observation, the Kitchen Manager stated that she was not aware of any insects in the kitchen and that no staff had complained of seeing any insects. In an interview conducted on 09/29/25 at 12:30 PM with the Kitchen Manager, she stated that the cook in the kitchen observed insects and reported it in a special pest control binder on 09/21/25. A review of the pest control visit forms, which were provided by the facility's Administrator, showed the following: a visit was conducted on 03/28/25 and on 09/02/25. Another visit was conducted on 09/29/25 after the surveyor's intervention. In an observation conducted on 10/01/25 at 11:00 AM during the lunch tray line, the following were noted:Staff D, Cook, was observed at the tray line taking the temperatures of the food items. She took the temperature of cooked pasta using a facility-calibrated thermometer. Staff D inserted the thermometer deep into the past tray, touching the pasta with her bare hands in the process. Staff D, Cook, was observed taking the temperature of the fortified pureed pasta using a facility-calibrated thermometer. She was observed taking the thermometer of the pasta tray while touching the serving ladle with her bare hands. Staff D, Cook, was observed taking the temperature of the mashed potato using a facility-calibrated thermometer. She was observed taking the thermometer of the pasta tray while touching the serving ladle with her bare hands. She did not replace the serving ladle with a new, clean one.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to initiate a care plan for advance directives for 5 of 5 sampled residents, Resident #10, Resident #27, Resident #60, Resident #72 and Resident #99; and failed to initiate care plans for 1 of 1 sampled resident reviewed for catheter, Resident #126.The findings included:1. Record review showed Resident #10 was admitted on [DATE] with diagnosis of cerebrovascular disease and vascular dementia, severe with anxiety. The Quarterly Minimum Data Set (MDS) dated [DATE] revealed the Brief Interview of Mental Status (BIMS) score was 06, indicating severe cognitive impairment. A review of the Physician's Orders showed Resident #10 had an order dated 02/03/25 for DNR (Do Not Resuscitate). A review of the Care Plan dated 08/25/25 documented that Resident #10 had a terminal diagnosis. The Goals were to support with management of signs and symptoms of depression and/or anxiety by the next review date. The interventions included honoring advanced directives (refer to advanced directives care plan). No advanced directives care plan were noted in the care plans. 2. Record review showed Resident #27 was admitted on [DATE] and readmitted on [DATE] with diagnosis of nontraumatic compartment syndrome of left lower extremity and chronic obstructive pulmonary disease. The Quarterly MDS dated [DATE] revealed the BIMS score was 09, indicating severe cognitive impairment. A review of the Physician's Orders showed Resident #10 had an order dated 01/31/25 for DNR. A review of the Care Plans dated 09/22/25 revealed that no care plan for advanced directives was elaborated. In an interview conducted on 10/01/25 at 5:25 PM with the Director of Nursing (DON), she stated she acknowledged the issue about the terminal diagnosis care plan for Resident #10 stating to refer to the advance directives care plan no advance directives care plan to review. 3. Record review for Resident #126 revealed the resident was admitted to the facility on [DATE] with diagnoses that included in part the following: Bladder-Neck Obstruction. The Minimum Data Set, dated [DATE] documented in Section C a Brief Interview of Mental Status score of 14, intact cognition. Review of the Physician's Orders for Resident #126 revealed in part the following: An order dated 09/19/25 for Enhanced Barrier Precautions every shift: An order dated 09/19/25 for urinary catheter care daily and PRN (as needed). Record review revealed there was no order for Contact Precautions. Review of the care plan for Resident #126 dated 09/17/25 documented a focus on trauma informed care with a goal of the frequency or severity of my trauma related signs and symptoms will not increase. The interventions included in part the following: Know what triggers are and minimize (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	exposure if possible. On 09/29/25 at 10:40 AM an observation was made of Resident #126 sitting in his wheelchair in his room with urinary drainage bag covered hanging from the side of his wheelchair. There was an Enhanced Barrier Precaution sign on the entrance door to the resident's room. An interview was conducted on 09/29/25 at 10:40 AM with Resident #126 who was asked if staff provide care for his catheter. He said some do and some do not, it is not done every day. Sometimes he has to empty his own bag. There was no care plan for EBP and no order for contact precautions but the care plan for Contact precaution for blood infection documented Resident #126. 4. (a) Record review for Resident #99 revealed the resident was admitted to the facility on [DATE] with diagnoses that included in part the following: Cerebral Infarction Due to Embolism of Left Middle Cerebral Artery, Other Lack of Coordination, and Aphasia. Review of the Minimum Data Set, dated [DATE] documented in Section C a could not be conducted due to the resident is rarely/never understood. Review of the Physician's Orders for Resident #99 revealed no order for any ointments or gels to be applied topically. Record review revealed no assessment for self-administration of medication. On 09/29/25 at 10:39 AM an observation was made of 2 over the counter medications (Ultra Strength Muscle Rub with active ingredients: Camphor 4%, Menthol 10% and Methyl Salicylate 30% and triple antibiotic ointment with active ingredients: Bacitracin Zinc, Neomycin Sulfate, and Polymyxin B Sulfate) on the overbed table next to Resident #99 who was sitting next to the overbed table. During an interview conducted on 09/29/25 at 10:39 AM with Resident #99 who was asked if she uses the creams on her overbed table, she shook her head yes. When asked where she puts the medicine, she pointed to the muscle rub and motioned a rubbing motion on her left arm. When asked about the triple antibiotic ointment she stroked her right leg. An interview was conducted on 09/30/25 at 11:38 AM with Staff B Licensed Practical Nurse (LPN), who was asked if residents can have medications at the bedside. The LPN stated no, the residents are not supposed to have medications at the bedside. On 09/30/25 at 11:42 AM a side-by-side observation was made with Staff A, Registered Nurse/Unit Manager (RN/UM), of Resident #99 in her room sitting next to her overbed table and on the overbed table was a tube of triple antibiotic ointment. The RN/UM acknowledged the triple antibiotic ointment was on the overbed table and stated residents are not supposed to have medications at the bedside. There was no care plan in place for the resident to self-administer medications. Review of the Physician's Orders for Resident #99 revealed an order dated 02/10/25 for full resuscitation (full code). Review of the Care Plan for Resident #99 revealed no care plan for code status or advance directives. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 10/01/25 at 11:15 AM with Staff the Clinical Reimbursement Specialist (LPN /CR). The CRD had left as of 09/12/25.When asked about care plans, she said the CRD who had left was in charge and they both (CRS's) and all nurses put in care plans. Social services does advanced directives and behavioral care plans. Further interview with the CRS revealed that every resident had an Advance directive care plan and as of 04/30/25 she was instructed by Palm Beach office to remove all advanced directive care plans and that is what she did, she removed all advanced care plans for every resident. She had questioned the removal, but she was instructed to remove all advance directive care plans for all residents. At the care plan meetings for the residents the social worker discusses advanced directives and verifies the code status for the resident and asks if they wish to continue with current code status or change it. An interview was conducted on 10/01/25 at 11:52 AM with the Social Services Director (SSD) who stated she has worked at the facility for 1 year. When asked about advance directives, the SSD said she addresses the advance directives at the time of admission, and it is discussed for sign change and quarterly reviews. The code status is on the face sheet and in the orders and if they are a DNR (Do Not Resuscitate), it is in front of the chart. The SSD said she believes that is why they do not have an advanced directive care plan. The SSD acknowledged there is no advance care plans are in place for any resident. 5. Resident #60 was originally admitted to the facility on [DATE] with most recent readmission on [DATE] with diagnoses that included in part the following: Chronic Obstructive Pulmonary Disease, Acute Pulmonary Edema and Allergic Bronchopulmonary Aspergillosis. The Minimum Data Set, dated [DATE] documented in Section C, a BIMS score of 15 indicating a cognitive response. Review of the Physician's Order for Resident #60 revealed an order dated 06/17/25 for DNR (Do Not Resuscitate), Review of the Care Plan for Resident #60 revealed no care plan for advanced directives or for code status. 6. Record review revealed Resident #72 was originally admitted to the facility on [DATE] with most recent readmission on [DATE] with diagnoses that included in part the following: Guillain-Barre Syndrome, Pain due to other Internal Prosthetic Devices, Implants and Grafts. Review of the Minimum Data Set assessment dated [DATE] documented in Section C, a BIMS score of 15, indicating a cognitive response. Review of the Physician's Orders for Resident #72 revealed an order dated 08/23/25 for full resuscitation. Review of the Care Plans for Resident #72 revealed no care plan for advanced directives or code status.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, and facility policy review, the facility failed to provide services with reasonable accommodation of resident needs and preferences for 3 of 27 sampled residents, (Resident #44, Resident #90, and Resident #104), whose call lights were not within their reach. The findings included: Review of the provided Policy and Procedure titled, Physical Environment, included #5: Assure an applicable working system is in place and within reach for the resident to summon assistance, including, but not limited to a typical call light with cord. The findings included:1. Record review revealed Resident #44 was readmitted to the facility on [DATE] with diagnoses that included: Cerebral Infarction, Weakness, Lack of Coordination, and Dementia. The Annual Minimum Data Set (MDS) dated [DATE], section C, documented a Brief Interview of Mental Status (BIMS) score of 06, on a scale of 0 to 15, indicating severe cognitively impaired. Review of the Activities of Daily Living (ADL) Care Plan had an intervention dated 10/06/22 Call Bell within reach while in room/bathroom/shower room and remind to use.During an observation conducted on 09/29/25 at 11:08 AM Resident #44 was noted in bed. The surveyor observed the resident's call light hanging on the back of the bed and not accessible to the resident. Photographic Evidence Obtained.2. Record review revealed Resident #90 was admitted on [DATE] with diagnoses that include: Lack of Coordination, Hypertension, Repeated Falls (05/15/2025), Anemia, Diabetes, and Dementia. The Quarterly MDS dated [DATE] section C, documented a BIMS score of 01 indicating severe cognitive impairment. The Care Plan for Resident #90 included a Fall Care Plan which stated, Provide environmental adaptations: Call light within reach, which was revised 09/22/25.During an observation on 09/30/25 at 9:22 AM, the call light for Resident #90 was on the floor next to his bed and not accessible to the resident. Photographic Evidence Obtained.3. Record review revealed Resident #104 was last readmitted on [DATE] with diagnoses that included Multiple Sclerosis, Hemiplegia and Hemiparesis after Cerebral Infarction (Stroke), Lack of Coordination, Malaise, and Chronic Pain. Her MDS readmission assessment dated [DATE] section C, reflected a BIMS score of 15 indicating cognition is intact. Section GG documented Resident #104 required substantial/maximum assistance to Roll left and right: The ability to roll from lying on back to left and right side and return to lying on back on the bed. The Plan of Care for Resident #104 had a Fall Care Plan with an intervention that stated Provide environmental adaptations: Call light within reach initiated on 07/28/25. During an observation on 09/30/25 at 9:20 AM, the call light for Resident #104 was on the floor next to her bed where she could not reach. Photographic Evidence Obtained. An interview was conducted on 10/01/25 at 10:45 AM, with Staff H, Certified Nursing Assistant (CNA), when asked about training she had been provided regarding call light policies, she replied that when daily care is completed, the call light is placed on the resident's bed near the resident's hand and then informed to call for help if needed. An interview was conducted on 10/01/25 at 1:00 PM with Staff J, CNA, regarding the call light policy. Staff J stated that once resident care was completed, she places the call light next to the resident on the bed where the resident can reach it.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to support the choices, activities, and schedules for 1 of 4 sampled residents reviewed for choices, Resident #8.The findings included: Record review revealed Resident #8 was readmitted to the facility on [DATE] with diagnoses of Heart Failure and Diabetes. Review of the Annual Minimum Data Set, dated [DATE], section C for Brief Interview of Mental Status (BIMS), showed a score of 15, indicating intact cognition. On 09/29/25 at 11:46 AM, Resident #8 stated that about a month ago, he noticed the television (TV) screen on his side was shattered and was on top of the nightstand, which was not his TV. He reported the findings to staff, who all denied breaking it, and was told that he would need to buy one on his own to replace the broken TV. The Quarterly Activity assessment dated [DATE] revealed that Resident #8's activity of choice was watching TV. The Activity Care Plan dated 07/23/25 revealed that Resident #8 will be encouraged to participate in activities of choice. In an interview with the Maintenance Director on 10/01/25 at 12:39 PM, he stated when he started working, he was told that only the South Wing, which is the short-term wing residents, have TVs in their rooms (Rooms 1-26). They provide some rooms with TVs for the long-term residents, but not for all the rooms. If other residents want TVs, they must purchase them themselves or have a family member buy their own TVs. When asked about Resident #8, he stated that he had a TV on the nightstand, which fell off and broke. He threw the broken TV out and told Resident #8 that he would ask the former Administrator if he was willing to purchase a new TV, which was about two to three months ago. The Maintenance Director stated he also spoke to Staff F, the Social Worker, regarding replacing the broken TV for Patient #8. He was also told by the former Administrator that they were purchasing extra TVs, but he did not hear anything back regarding the new TVs. In an interview conducted on 10/01/2025 at 12:50 PM with Staff F, she stated that only the skilled nursing residents who are here for the short term have TVs in their rooms. Resident #8 came to her office to let her know that his TV was broken, which was about 6 weeks ago, and told her that he did not break the TV. She told Resident #8 that he was a long-term resident, and if he wanted his TV replaced, he would have to purchase his own TV. Resident #8 was also told that his family could buy the TV or pay the facility for the TV, and they would be pleased to purchase the TV for him. Resident #8 refused to buy the TV on his own or have his family pay for the TV. Staff F also offered Resident #8 a room change to another room, which had a TV in it, and he refused. When asked if she filed a grievance regarding the broken TV for Resident #8, she said, To be honest, I do not know. A tour of the facility, conducted by the Maintenance Director on 10/01/25, at 2:00 PM, revealed that 21 rooms were missing televisions, while 42 rooms had televisions in them. After this tour, the Surveyor expressed concerns that some rooms have TVs in them, and some do not.

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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 observation, interviews and record review, the facility failed to ensure that the resident environment remained free of accident hazards and failed to ensure that fall interventions were followed for 1 of 1 sampled resident reviewed for accidents, Resident #90. The findings included:Review of the Fall and Injury Reduction Policy effective March 2023 stated that the facility had designated and implemented processes, which strove to reduce the risk for falls and injuries. The policy guided the identification and implementation of appropriate interventions. One of the specifications included implementation of a plan of care based on individual resident needs. Record review revealed Resident #90 was admitted on [DATE] with diagnoses which included Type 2 Diabetes Mellitus, Repeated Falls, and Dementia. Review of the Minimum Data Set (MDS) assessment dated [DATE], section C, documented Resident #90 had a Brief Interview for Mental Status (BIMS) score of 1, on a 0 to 15 scale, indicating the resident's cognition was severely impaired. Resident #90 experienced two documented falls on 09/18/25 and 06/28/25. Resident #90's care plan was updated after the falls and included the following interventions: floor mats when in bed, checking on the Resident every 30 minutes, call light within reach, and area free of clutter. In an observation conducted on 09/30/25 at 9:22 AM, the call light for Resident #90 was on the floor next to his bed and not within reach. Photographic Evidence Obtained. In an observation conducted on 09/30/25 at 4:32 PM and at 6:00 PM, Resident #90 was noted in his bed sleeping with bilateral mats on both sides of the bed. A wheelchair was noted next to the air conditioner on top of the right mat blocking it, if a fall was to occur. Photographic Evidence Obtained. During an interview with the Director of Nursing (DON) on 09/30/25 at 4:40 PM, she provided the facility's policy for falls. During the interview, she was asked what was implemented after Resident #90 had a fall. She replied that any new interventions are recorded in the care plan on the same day or the next day. The interventions are placed in the care plan but not necessarily ordered. After the first fall, Resident #90 care plan was updated with every 30-minute checks and after the second fall, bilateral mats were initiated and care planned. An interview was conducted on 10/01/25 at 10:45 AM with Staff H, Certified Nursing Assistant (CNA) who stated that she had been working for the facility for about 4 to 5 months. When asked regarding call light procedures, Staff H stated that when daily care is completed, the call light is placed on the resident's bed near the resident's hand and then informed to call for help if needed. Staff H was then asked how often she checks on Resident #90 when in his room, she replied every 30-40 minutes. Staff H was asked if Resident #90 was at risk for falls. She stated, No. When asked if Resident #90 had any interventions for falls she replied, No. Staff H then added Resident #90 had mats and his bed was placed in low position when in bed. According to Staff H the floor mats were dirty and cleaned that day. Staff H was asked where the wheelchair is placed when Resident #90 is in bed, she replied, I fold the wheelchair and place it behind the bed. Staff H also stated that the footrests are placed in the closet.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure tube feeding orders were followed as per the physicians' orders and failed to address a significant weight loss in a timely manner for 1 of 3 sampled residents reviewed for tube feeding (Resident #5). The findings included: Review of the facility's policy titled Weight Management, dated January 2021, showed the following: the Dietitian will document assessment of weight change and intervention. The Dietitian will identify significant weight changes with the following: 1 week 2%, 1 month 5%, 3 months 7.5% and 6 months 10%. Record review revealed Resident #5 was readmitted to the facility on [DATE] with diagnoses of End Stage Renal Disease, Moderate Calorie and Protein Malnutrition, and Type 2 Diabetes. The Quarterly Minimum Data Set (MDS) assessment dated [DATE], Section C, showed Resident #5 had severe cognitive impairment.Review of Resident #5's weight log showed the following:On 09/05/25, the weight was 124.8 pounds. On 08/07/25, the weight was 125.6 pounds. On 07/04/25, the weight was 139.2 pounds. This showed a weight loss of 10% in two months.An order was noted for two times Jevity 1.5 (tube feeding formulary) at 85 milliliters (ml) per hour for a total of 1,275 ml infused over 24 hours, starting at 4:00 PM on 07/11/2025.On 09/30/25 at 8:35 AM, an observation noted Resident #5 in bed with the Jevity 1.5 tube feeding running at 85 mL/hour. The tube feeding bottle was started on 09/30/25 at 4:00 AM and was noted at the 850 ml mark out of a 1000 ml capacity bottle. The tube feeding that started at 4:00 AM, running at 85 ml per hour, should have been around the 618 ml level, not around the 850 ml level.In an observation conducted on 09/30/25 at 11:25 AM, Resident #5 was noted in bed with the tube feeding Jevity 1.5 formulary on hold. The same bottle observed earlier was noted at the 750 ml mark out of a 1000 ml capacity bottle. In an observation conducted on 09/30/25 at 4:11 PM, with tube feeding Jevity 1.5 running at 85ml an hour. The same tube feeding bottle observed earlier was still noted at the 750 ml mark out of a 1000 ml capacity bottle. In an observation conducted on 09/30/25 at 6:25 PM, with tube feeding Jevity 1.5 running at 85 ml an hour. The same tube feeding bottle observed earlier was noted at the 600 ml mark out of a 1000 ml capacity bottle.An observation conducted on 10/01/25 at 8:13 AM revealed that Resident #5 was in bed with the tube feeding on hold. Tube feeding was initiated with Jevity 1.5 at 85 mL/hour, starting on 10/01/25 at 6:40 AM. The tube feeding was noted at the 950 ml mark out of a 1000 ml capacity bottle.A review of the Quarterly Nutrition Note dated 09/24/25, which was about 3 weeks after Resident #5's significant weight loss was identified, showed the following: Triggering for substantial weight loss times 3 months, weight fluctuations anticipated secondary to diagnosis and medications with diuretic tendencies. It further showed Resident #5 had increased needs secondary to a low underweight Body Mass Index (BMI) of 18.4.The Care plan dated 07/10/25 outlined the following: maintaining adequate nutrition and hydration to prevent significant weight changes, collaborating with the dialysis center, and monitoring weight changes. In an interview conducted on 10/01/25 at 9:17 AM, with the facility's Registered Dietitian, she stated that weights are taken upon admission, once a week for 4 weeks, and monthly thereafter unless more weights are needed. Residents on dialysis are considered high-risk residents and are followed once a month by her. When asked about significant weight loss, she reported the following: 1 week, 2%; 1 month, 5%; 3 months, 7.5%; and 6 months, 10%. For any significant weight loss, they intervene immediately and discuss the weight loss in the morning meetings. When asked how she knew that someone had experienced considerable weight loss, she stated that she runs the weekly weights from the electronic system and compares them to the weights from prior weeks. For the monthly weights, a list of all residents is provided to the nursing team. Weights are taken on the first day of the month and are due to be entered into the electronic system by the 7th of the month. She runs the monthly weight report so she can intervene immediately for any residents experiencing significant weight loss. In this interview, the Dietitian agreed that Resident #5 had a (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	considerable weight loss and that she had not addressed it promptly. In an interview conducted on 10/01/2025 at 1:30 PM with Staff E, Licensed Practical Nurse (LPN), she stated that Resident #5 is tolerating the tube feeding well with no issues. She further noted that the tube feeding bottle had started this morning at 6:40 AM and was already running when she arrived for her shift.

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Pompano Health and Rehabilitation Center	51 W Sample Road Pompano Beach, FL 33064

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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 observation, interview and record review, the facility failed to provide respiratory care in a manner consistent with physician orders for 2 of 2 sampled residents (Residents #85 and #46) reviewed for respiratory and failed to assure resident care policies and procedures for respiratory care and services are developed affecting 1 of 3 tracheostomy residents (Resident #85.)The findings included: 1. Review of the record revealed Resident #85 was admitted to the facility 04/08/25 with diagnoses of Traumatic Subdural Hemorrhage (a type of bleeding near your brain that can happen after a head injury); acute and chronic respiratory failure with hypoxia, and anoxic brain damage. Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented Resident #85 had a Brief Interview for Mental Status (BIMS) score of 0, on a 0 to 15 scale, indicating the resident was severely cognitively impaired. This same MDS indicated Resident #85 received treatments such as tracheostomy care, oxygen therapy, and suctioning. Review of active orders revealed Resident #85 had an order that documented Trach: Suction Trach Pre Record Lung Sounds, HR (heat rate) and Respirations as needed for suction prn (as needed) and an order that documented Trach: Suction Trach Post Record Amount of Secretions Characteristics of secretions: (Color, Odor, Viscosity) Lung Sounds, HR, Respirations and Tolerance as needed for Suction prn. Review of Resident #85's care plan dated 07/16/25 documented Focus: Tracheostomy: The resident has a Tracheostomy. Goal: The resident will have no signs and symptoms of infection through the review date; Will have no abnormal drainage around trach site through the review date. Interventions/Tasks: Monitor/document respiratory rate, depth and quality. Check and document every shift/as ordered. Trach care per order. The care plan also documented, Focus: Altered Respiratory Status: The resident has altered respiratory status/Difficulty breathing related to tracheostomy status, Respiratory Failure with hypoxia. Review of Resident #85's Treatment Administration Record (TAR) from September 1st-30th revealed there was no documentation for the pre and post tracheostomy suction assessments for the entire month. A tracheostomy care observation for Resident #85 was conducted on 10/01/25 at 11:37 AM with Staff B, Licensed Practical Nurse (LPN). Upon entering the room Staff B performed hand hygiene and donned Personal Protective Equipment (PPE) which included a gown and gloves. Staff B began by setting up her supplies and continued with tracheostomy care. A respiratory assessment was not performed by Staff B. Staff B stated she would require assistance from another staff member to put on Resident #85's tracheostomy collar due to safety concerns. On 10/01/25 at 11:55 AM, Staff P, Certified Nursing Assistant (CNA) entered the room to assist. Staff B changed Resident #85's collar and during the process the resident began to cough and expel secretions, Staff B verbalized that she would suction the Resident. Staff B performed deep suctioning, mouth suctioning, and cleansed the resident's secretions. Staff B concluded her care, discarded her supplies, and washed her hands. Staff B was asked if she was done with her care and stated yes then walked out of Resident #85's room. Again, Staff B did not perform a respiratory assessment on Resident #85. An interview was conducted with Staff B on 10/01/25 at 12:17 PM. When asked, how would you perform a respiratory assessment, Staff B stated she would check their oxygen, check for lung (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sounds, and check for respirations. When asked when would you perform a respiratory assessment, Staff B stated, If they are wheezing, coughing, in distress, or if there is a change of condition. When asked if she would do an assessment for an administration of a respiratory treatment, Staff B stated yes and verbalized she would do it for any nebulizer treatment and tracheostomy care. When asked why she didn't perform an assessment before and after performing tracheostomy care that included deep suctioning, for Resident #85, Staff B stated she forgot her stethoscope and had left it out on her medication cart and had her pulse oximeter in her pocket but forgot to use it. Staff B stated she would have also checked respirations but didn't because she was nervous. Staff B voiced they were rushing me to do tracheostomy care. On 10/01/25 at 2:30 PM, when asked to provide a respiratory and tracheostomy policy, the Regional Nurse Consultant voiced they did not have a respiratory or tracheostomy policy and used the tracheostomy care competency skills checklist. Staff B's competencies were requested for review. Review of Staff B's competency titled Tracheostomy Care Competency Skills Checklist dated 07/01/25 and labeled New Hire documented, Competency Criteria: Tracheostomy Care . 1. Check TAR to verify physician orders for trach care . yes. All other criteria for the skill had also been checked of as yes and was signed by both Staff B and a representative facilitating the competency on 07/01/25. Review of Staff B's competency titled Competency Review Nurses dated 07/01/25 documented, Required competency . Nursing Care to Residents . Demonstrates knowledge and understanding of physical assessment as follows: Respiratory 1. Breath Sounds: Trach care/suctioning. All skills were verified and signed off by the evaluator as well as by Staff B on 07/01/25. On 10/02/25 at 12:54 PM, the Regional Nurse Consultant asked the surveyor how Staff B did with Tracheostomy care. She was informed Staff B did not perform a pre and post assessment when she performed care. The Regional Nurse Consultant stated Staff B was really nervous and was a newer nurse. She agreed with all findings. 2. Review of the facility policy for Oxygen Therapy stated that oxygen is provided to residents based on physician orders and the first step of the policy is to verify the physician order. Review of the record revealed Resident #46 was last readmitted on [DATE] with diagnoses that included Acute Respiratory Failure, Chronic Respiratory Failure, Morbid (Severe) Obesity, Chronic Obstructive Pulmonary Disease, Type 2 Diabetes, Shortness of Breath, and Pleural Effusion. Review of the current Quarterly Minimum Data Set (MDS) assessment dated [DATE], section C, documented the resident had a Brief Interview for Mental Status (BIMS) score of 14, on a 0 to 15 scale, indicating the resident's cognition was intact. Further review of Resident #46 is record indicated there was no physician order for oxygen therapy. The care plans initiated 12/03/20 and revised 03/25/25 for Resident #46 however did have a current plan for oxygen and included monitoring for signs and symptoms (S/S) of respiratory distress and breathing difficulty. Resident #46's Treatment Administration Record (TAR) for the months of September and October 2025 did not include monitoring for these S/S. Review of the Nursing progress notes did not address oxygen use after 05/25/25. Oxygen saturation, a medical measurement which is a key indicator of oxygen levels, was not measured after the month of July 2025. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/29/25 at 11:10 AM, during Resident #46 she was observed in her room sitting in her wheelchair wearing a nasal canula. Further observation revealed that an oxygen concentrator was running with the flow meter above the highest mark (5 liters/L). Photographic Evidence Obtained. On 09/29/25 at 1:55 PM, Resident #46 was observed in her room. The resident stated that she needed oxygen all the time when asked how often it was used. The resident also used the portable oxygen tank on the wheelchair outside of her room. Resident #46 stated that she previously needed 1-2 L but it was increased to 3-4 L. On 09/30/25 at 8:36 AM, Resident #46 was observed with a portable oxygen tank attached to her wheelchair which was turned off since she was using the concentrator. The oxygen concentrator was running with the flow meter above the highest mark. Photographic Evidence Obtained of both concentrator and oxygen tank. On 10/01/25 at 8:37 AM, Resident #46 was observed using the oxygen concentrator running with the flow meter at 4.5 L. Photographic Evidence Obtained. During an interview on 10/01/25 at 1:00 PM with Staff J, Certified Nursing Assistant (CNA), Staff J stated that when Resident #46 was in bed, the concentrator was used and when she was in the wheelchair Resident #46 used the portable oxygen tank. Staff J stated that she helped Resident #46 into the chair and set the tank to 2 L but the concentrator was always set up ahead of time. When asked who set it up, Staff J did not provide a name or title. An interview was conducted on 10/01/25 at 2:10 PM Staff G, Nurses who stated that Resident #46 required oxygen most of the time. Staff G explained that Resident #46 used the concentrator at night, and the portable oxygen tank on wheelchair in the day. Staff G stated that the second shift nurse would set up the concentrator according to the order in the chart. Staff G could not locate an oxygen therapy order for Resident #46 in the chart. The Assistant Director of Nursing (ADON) came over during the interview and could not find oxygen orders and noted they were discontinued in July of 2025.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to obtain dialysis communication sheets for 1 of 1 sampled resident reviewed for dialysis (Resident #117). The findings included:A review of the facility's policy titled Dialysis Management, dated October 2021, revealed the following: The facility will coordinate care and services for hemodialysis residents. Complete the Dialysis Communication Tool before and after dialysis and follow up on any special instructions from the dialysis center. A record review revealed Resident #117 was readmitted to the facility on [DATE] with diagnoses of End Stage Renal Disease and was dependent on dialysis. A review of the physician's orders showed an order for the Resident to undergo dialysis on Tuesdays, Thursdays, and Saturdays, dated 09/26/25.The Nutrition Risk assessment dated [DATE] revealed the following: Resident #117 has a hyponatremic (low blood sodium) diagnosis and fluid fluctuations that are anticipated secondary to dialysis. Resident #117's care plan showed Collaboration with the dialysis center as one of the interventions.A review of the dialysis communication sheets for Resident #117, which were noted in the nurse's station, showed the following for the month of January 2025: Missing communication sheets were not in the dialysis binder for 09/04/25, 09/06/25, 09/13/25, 09/23/25, and 09/27/25. In an interview conducted on 09/30/25 at 4:15 PM with Staff C, the Registered Nurse stated that the communication sheets are filled out before the Resident goes to dialysis treatment. It is then filled out at the dialysis center and brought back to the facility with the Resident. All communication sheets are placed in a dialysis communication binder located in the nurse's station. In an interview conducted on 09/30/25, at 5:00 PM with the Director of Nursing (DON), she stated that when a resident goes to dialysis, facility staff fill out communication sheets. It is later completed by the dialysis center and returned to the facility. The nursing staff will review the communication sheets for any new orders or fluid restrictions and make the necessary changes. The communication sheets are later placed in the dialysis binder in the nurse's station, the same day. According to the DON, it is essential to review all communication sheets the same day after the residents come back from dialysis.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to identify triggers and implement care plans with triggers for residents with PTSD (Post Traumatic Stress Disorders) for 1 of 1 sampled resident, Resident #3.The fundings included:Record review revealed Resident #3 was admitted on [DATE] with diagnoses that included of the Psychosocial History and Assessment for Resident #3 dated 07/16/25 documented the following, resident has been diagnosed with PTSD. Is there a smell, sound, touch, taste, sight or other sensation that causes a flashback or trigger was answered yes. If yes, what causes flashbacks or triggers was answered being in situations where he feels anxiety. When asked what happens when the resident experiences a trigger was answered Increased anxiety. Review of Resident #3's Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognitive response. Review of the Care Plan for Resident #3 dated 07/14/25 documented with a focus on Trauma Informed Care. The goals were for staff to make efforts to avoid flashback or trigger, staff will assist in managing the resident's response to trigger, and the frequency or severity of the trauma related signs and symptoms will not increase. The interventions included in part the following: Know what triggers are and minimize exposure if possible. Observe for reported symptoms of a trigger. During an interview conducted on 10/01/25 at 11:15 AM with Staff LPN/CRS (Clinical Reimbursement Specialist) and has been in this role at the facility since November 2024. When asked about care plans, she said the CRD (Director) that just left was in charge and both her, the Director and all nurses put in care plans. Social Services does advance directives and behavioral care plans. During an interview with the Social Services Director (SSD) on 10/01/25 at 11:52 AM, when asked about residents with diagnosis of PTSD, the SSD stated if a resident has PTSD, this is addressed by her on the admission psychosocial assessment, and this would include the triggers for the PTSD. She stated the trauma informed care portion of the psychosocial assessment would automatically pull over to the care plan for the resident and create a trauma informed care plan. When asked about Resident #3, the SSD stated he does have PTSD and he also has triggers. When asked what the triggers are, the SSD stated being in situations where he feels anxiety. It's a delicate situation and use a calm delicate quiet approach.Sense of situational anxiety, and she feels the resident is still trying to figure it out. An interview was conducted on 10/01/25 at 1:20 PM with the Director of Nursing, the Social Service Director and Staff R, Psychologist, to review Resident #3 and his triggers. Staff R stated she has been seeing the resident since July of this year. When asked if he has any triggers for the PTSD she said yes, he mentioned it 2 to 3 times about the yelling that he does not like it and he gets anxious. Staff R said she has mentioned this to staff and asked to have his room or roommate changed to help and staff did change his room a couple of times and this has helped the resident.

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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 record review and interview, the facility failed to ensure adequate medication for 1 of 6 residents, Resident #39, reviewed for medication reconciliation.The findings included:On [DATE] at 11:50 AM, a review of the North medication care was conducted with Staff G, Licensed Practical Nurse (LPN) for Resident #39. Record review reveled Resident #39 was admitted on [DATE] with diagnoses that included Parkinson's Disease, and Dementia Review of the physician's order, dated [DATE], documented Alprazolam Oral Tablet 0.25 MG (Alprazolam), a *Controlled Drug,*Give 1 tablet by mouth every 12 hours as needed for Anxiety/Agitation for 14 Days and was discontinued on [DATE]. Review of the Controlled Drug Declining Inventory Sheet for Resident #39 for the Alprazolam .25mg tablet documented the medication was signed out on [DATE] at 8:24 PM. Review of medication administration record from 0701/25 to [DATE] revealed no documentation of Alprazolam 0.25mg being administered. Review of the nurse progress notes from [DATE] revealed no documentation of Alprazolam 0.25mg being administered. During an interview conducted on [DATE] at 1:00 PM with the Director of Nursing who was asked about controlled medication reconciliation, she said she reviews the carts regularly with the nurses to ensure expired or discontinued medication or medications for residents who have been discharged are removed from the carts. When asked about the Alprazolam 0.25mg for Resident #39, she acknolwedged the medication was discontinued was not documented as being administered on [DATE].

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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 record review, observation and interview, the facility failed to ensure medication were secured, for 1 of 27 sampled residents, Residents #99, reviewed for medications. The findings included:Record review for Resident #99 revealed the resident was admitted to the facility on [DATE] with diagnoses that included in part the following: Cerebral Infarction Due to Embolism of Left Middle Cerebral Artery, Other Lack of Coordination, and Aphasia. Review of the Minimum Data Set, dated [DATE] documented in Section C a Brief Interview of Mental Status could not be conducted due to the resident is rarely/never understood. Review of the Physician's Orders for Resident #99 revealed no order for ointments or gels to be applied topically. Record review revealed no assessment for self-administration of medication(s). On 09/29/25 at 10:39 AM, an observation was made of 2 over the counter medications (Ultra Strength Muscle Rub with active ingredients: Camphor 4%, Menthol 10% and Methyl Salicylate 30% and triple antibiotic ointment with active ingredients: Bacitracin Zinc, Neomycin Sulfate, and Polymyxin B Sulfate) on the overbed table next to Resident #99 who was sitting next to the overbed table. An interview was conducted on 09/29/25 at 10:39 AM with Resident #99 who was asked if she uses the creams on her overbed table. She nodded her head yes. When asked where she puts the medicine, she pointed to the muscle rub and motioned a rubbing motion on her left arm. When asked about the triple antibiotic ointment, she stroked her right leg. During an interview conducted on 09/30/25 at 11:38 AM with Staff B Licensed Practical Nurse (LPN) who was asked if residents can have medications at the bedside, the LPN stated, no the residents are not supposed to have medications at the bedside. On 09/30/25 at 11:42 AM, a side-by-side observation was made with Staff A Registered Nurse/Unit Manager (RN/UM), of Resident #99 in her room sitting next to her overbed table and on the over bed table was a tube of triple antibiotic ointment. The RN/UM acknowledged the triple antibiotic ointment was on the overbed table and stated residents are not supposed to have medications at the bedside.

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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 ensure they implemented an effective infection control program, as evidenced by failure to follow enhanced barrier precautions guidelines for 1 of 42 residents on enhanced barrier precautions, Resident #25.The findings included:Review of the facility's policy titled, Barrier Precautions dated August 2025, included the following: During high-contact resident care activities: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting for Residents on Enhanced Barrier Precautions, Personal Protective Equipment (PPE) is required. PPE consists of wearing gloves and gown prior to the high contact care activity.Post clear signage on the door or wall outside of the resident room indicating the type of Precautions and required PPE. For Enhanced Barrier Precautions, signage should also clearly indicate the high-contact resident care activities that require the use of gowns and gloves. Make PPE, including gowns and gloves, available immediately outside of the resident room. A record review showed that Resident #25 was admitted on [DATE] and readmitted on [DATE] with diagnosis of type 2 Diabetes Mellitus with diabetic neuropathy and foot ulcer. The Quarterly Minimum Data Set (MDS) dated [DATE] revealed that the Brief Interview of Mental Status (BIMS) score was 12, moderate cognitive impairment.A review of the Physician's Orders showed that Resident #25 had an order dated 06/13/25 for Enhanced Barrier Precautions.A review of the Care Plan dated 08/04/2025 documented that Resident #25 had diabetic ulcer of left medial foot. Goals were the improvement of ulcers without complications by the next review date. The interventions included enhanced barrier precautions.In an observation conducted on 09/29/25 at 12:30 PM, the surveyor called Staff K, Unit Manager Registered Nurse (RN) per Resident #25s request. Staff K entered Resident #25 accompanied by Staff L, Staff M and Staff N. The staff members washed their hands, put gloves on and dressed Resident #25, transferred, the resident from the bed to the wheelchair and wheeled resident to the bathroom. Resident #25 urinated on the wheelchair. Staff members wheeled Resident #25 to the room, took its vital signs, transferred the resident back to bed and provided care. During this event Staff K, Staff L, Staff M, and Staff N did not wear the required Personal Protective Equipment (PPE).In an interview conducted on 10/02/25 at 11:00 AM, the Director of Nursing (DON) stated that whenever staff are providing ADL (activities of daily living) care they would use PPE. The staff would use PPE that consists of gloves and a gown, and the mask is optional when they are transferring, toileting and providing care. The DON was made aware of the findings.In an interview conducted on 10/02/25 at 1:15 PM with Staff K, Unit Manager Registered Nurse, she further stated that when a resident is on enhanced barrier precaution, she has to wear a gown and gloves if she is going to care for the resident or transfer the resident. The only time she doesn't need to wear the personal protective equipment is if she is just going to check on the resident.In an interview conducted on 10/02/25 at 1:30 PM with Staff O, Certified Nurse Assistant, she stated that the enhanced barrier precautions mean when she goes in the room, she has to wear a gown and gloves because the resident could be on tube feeding, on ventilator, or tracheostomy, or could have wounds.

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide influenza and pneumococcal vaccines for 2 of 5 sampled residents, Resident #60 and Resident #126.The findings included: 1. Record review for Resident #126 revealed the resident was admitted to the facility on [DATE] with diagnoses that included in part the following: Muscle Wasting and Atrophy and Pneumonia. Review of the Minimum Data Set, dated [DATE] documented in Section C a Brief Interview of Mental Status score of 14 indicating a cognitive response. Review of the Physician's Orders for Resident #126 revealed an order dated 10/02/25 for Inactivated Influenza Quadrivalent Vaccine 0.5 ML (Inactivated Influenza Quadrivalent Vaccine) Inject 0.5 ml intramuscularly one time only for Immunization for 1 Day Please employ the appropriate VIS for Flu vaccines. Please obtain consents for vaccines as well as enter information under the immunization tab. Review of the Vaccine Consent Form with no date for Resident #126 revealed it was signed by the resident and indicated he wanted the influenza and the PCV20 (Prevnar 20) (there was a check next to both immunizations. On the form was written Refused that did not look like the same pen/handwriting as the resident).Review of the declination of Influenza or Pneumococcal Vaccination dated 09/16/25 indicated Influenza (circled) and was signed by Resident #126.Review of the Vaccine Consent Form for Resident #126 dated 10/01/25 signed by the resident indicated he wanted the influenza vaccine (there was a check next to influenza).On 10/01/25 at 4:00 PM, the Staff I, the Unit Manager/Infection Preventionist, informed the surveyor that she had asked Resident #126 if he would like to receive the influenza vaccine and showed the surveyor the fax that she had sent to the pharmacy ordering the influenza vaccine for the resident. 2.Record review revealed Resident #60 was admitted to the facility on [DATE] with most recent readmission on [DATE] with diagnoses that included in part the following: Chronic Obstructive Pulmonary Disease, Acute Pulmonary Edema, Allergic Bronchopulmonary Aspergillosis, Morbid (Severer) Obesity, and Presence of Heart Assist Device. The Minimum Data Set, dated [DATE] documented in Section C a Brief Interview of Mental Status score of 15 indicating a cognitive response. Review of the Physician's Orders for Resident #60 revealed an order dated 10/01/25 for Prevnar 20 Intramuscular Suspension Prefilled Syringe 0.5 ML (Pneumococcal 20-Valent Conjugate Vaccine) Inject 0.5 ml intramuscularly one time only for Immunization for 2 Days. Review of the Declination of Influenza or Pneumococcal Vaccine form dated 07/07/25 which indicated Prevnar 20 was not signed by the resident.Review of the Consent for Flu and Pneumococcal Vaccine with dated 09/25/25 signed by Resident #60 documented the resident was administered the Flucel vaxOn 10/01/25 at 4:00 PM the Staff I; Unit Manager/Infection Preventionist informed the surveyor that she had asked Resident #60 if he would like to receive the pneumococcal vaccine and showed the surveyor the Vaccine Consent Form dated 10/01/25 signed by Resident #60 documenting the Prevnar20 was checked. During an interview conducted on 10/01/25 at 3:30 PM with Staff I was asked about immunizations being offered to residents, Staff I stated they are offered on admission and annually during the month of September. An interview was conducted on 10/01/25 at 10:20 AM with Resident #126 who was asked if he wanted the flu or pneumonia vaccine. He said he has always taken the flu vaccine so he would take that. He said he never had the pneumonia vaccine but should take it because he has had pneumonia in the past. When asked if staff ever offered him the flu or pneumonia vaccine, he said he did not remember it being offered to him.