

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106106	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2025
NAME OF PROVIDER OR SUPPLIER Glades West Rehabilitation and Nursing C		STREET ADDRESS, CITY, STATE, ZIP CODE 15955 Bass Creek Road Pembroke Pines, FL 33027	
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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to respond to call lights to provide ADL (Activities of Daily Living) care for 3 of 23 sampled residents reviewed for ADL's (Resident #99, Resident #110, Resident #70).The findings included:A review of the facility's policy titled Call Bell Policy and revised in December 2024 showed the following: Determine the resident's need, if you cannot perform, leave light on, find Nurse or CNA who can assist. Do not walk by. Turn off the call bell once needs are attended to and ensure it is within reach for the next use. Do not make the resident feel you are too busy to assist or respond.1. Record review revealed that Resident #70 was admitted to the facility on [DATE] with diagnoses of Dysphagia following Cerebrovascular Disease and Chronic Obstructive Pulmonary Disease. The Medicare 5 Day Minimum Data Set (MDS) assessment dated [DATE] revealed that the Resident Brief Interview of Mental Status (BIMS) score was 08, which indicates moderate cognitive impairment. Section GG of the MDS showed that Resident #70 needs substantial/maximal assistance during toileting hygiene, shower/bath self and is dependent for toilet transfer.During an observation conducted on 12/15/25 at 11:45 AM Resident #70 was seen lying in bed sleeping with a right knee immobilizer on. At that time, Resident #70 woke up and said that she was going to have a bowel movement. Resident #70 used the call light, as suggested by the surveyor. It was noted that the call light was audible at the nurse's station and the light was turned on in the hallway located on top of the room door. During the observation, it was noted that multiple staff members passed by the room and did not respond to the call light. The surveyor went ahead and called a nurse to assist the resident. The nurse answered that she will call a Certified Nurse Assistant (CNA) because she is not a CNA. Resident #70 persistently called out to the surveyor in distress saying: Muchacha Por favor cambiam. This surveyor went back to the room from the hallway more than 6 times and asked multiple nurses for help. All the nurses' answers were that they are busy. Staff A, the Registered Nurse Supervisor came and explained that the designated CNA is busy with another resident, but she is trying to find another CNA. At 12:15 PM, the Director of Nursing came and entered the room trying to calm Resident #70. A CNA later came into the room to change the Resident at 12:25 PM.2. Record review revealed that Resident #110 was admitted to the facility on [DATE] with diagnosis of Displaced Bicondylar fracture of left tibia and encounter for other orthopedic aftercare. The Medicare 5 Day Minimum Data Set (MDS) assessment dated [DATE] revealed that the resident's Brief Interview of Mental Status (BIMS) score was 15, which indicates no cognitive impairment. Section GG of the MDS showed that Resident #110 needs partial/moderate assistance during toileting hygiene, Substantial/Maximal Assistance during shower/bath self and toilet transfer is not attempted due to medical condition or safety concerns.During an interview conducted on 12/15/25 at 12:50 PM, Resident #110 stated that the aides take a long time to come to provide ADL care. When a long time was asked to quantify, Resident #110 further explained that today for example she had been waiting since 8:00 AM to get changed and it's already 12:50 PM. Resident #110 expressed that she felt very uncomfortable and dirty.3. Record review revealed that Resident #99 was admitted to the facility on [DATE] with diagnoses of displaced trimalleolar fracture of right lower leg and chronic atrial fibrillation. The Medicare 5 Day Minimum Data Set (MDS) assessment (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dated [DATE] revealed that the resident Brief Interview of Mental Status (BIMS) score was 08, which indicates moderate cognitive impairment. Section GG of the MDS showed that Resident #99 is dependent for toileting hygiene, shower/bath self and toilet transfer is not attempted due to medical condition or safety concerns. During an interview, conducted on 12/15/25 at 12:35 PM, Resident #99 stated that her colonic drainage fell out this morning and that she had been sitting in her dirty brief for over an hour now. The resident pointed to a pair of scrubs on a chair and explained that she wanted to wear them but unfortunately, no one came to help her. Resident #99 was very upset and kept on repeating that she wanted to get changed because she was dirty. At 12:40 PM, the paramedics came with a stretcher to take Resident #99 to the hospital to replace her colonic drainage. Resident #99 was screaming that she did not want to go to the hospital with a dirty brief on and that she had been waiting for hours now to get changed. The paramedics left the room and stood outside. At 12:50 PM, staff members were seen entering the room and the nurse stated that Resident #99 was a very complicated resident. During an interview, conducted on 12/18/25 at 10:00 AM, the Director of Nursing (DON) stated that she has been working in the facility for 3 years now. She further explained that a resident having a bowel movement should be cleaned as soon as possible. And that waiting 30 minutes is not an acceptable time to be changed. The DON was made aware of Resident #99 and explained that the CNA had to finish two residents that had appointments and had to go to therapy prior to changing Resident #99. The DON added that the expectation for the call light is to be answered right away. During an interview, conducted on 12/18/25 at 10:15 AM with the Registered Nurse Supervisor, Staff A, she stated that she has been working in the facility for 4 years. She further stated that she works the morning shift: 7:00 AM to 3:00 PM and that she is the Unit Manager on both floors. Per surveyors' question, Staff A answered that when a resident has a bowel movement, the expectation is to call a CNA or provide immediate help. If a CNA is busy a nurse can change the resident or take the resident to the restroom. When a call light is on, a staff member should go to the residents within minutes and a 30-minute wait is not acceptable. Even if a nurse that is not assigned to the wing is aware the call light is on, they should answer the call light regardless. On the day of the incident (12/15/25) Staff A was present and acknowledged that Resident #70 waiting 40 minutes to be changed after having a bowel movement is not up to the facility's standard. During an interview, conducted on 12/18/25 at 10:30 AM with Certified Nurse Assistant (CNA), Staff B, she stated that she has been working for the facility for 9 years. She further stated that she works the morning shift from 7:00 AM to 3:00 PM and the days vary. Per surveyors' question, Staff B answered that the expectation when a resident has a bowel movement is to use the call light. Staff explained that if she is not busy, she responds to the resident right away but if she is with another resident she asks a nurse to assist the resident until she is done and can get to the resident. If she is busy with a resident and the call light of another resident comes on, the nurse must assist the resident for her because it's teamwork. During an interview, conducted on 12/18/25 at 11:10 AM with Certified Nurse Assistant (CNA), Staff C, she stated that she has been working in the facility for 2 years and works the morning shift from 7:00 AM to 3:00 PM. She explained that once she sees the call light on, she has to go immediately to the room. Staff C further explained that if she is busy with a resident and she gets called because another resident is having a bowel movement, she will call another CNA to ask for help. She further explained that It is unacceptable for a resident to wait 30 to 40 minutes to get changed after having a bowel movement. During an interview, conducted on 12/18/25 at 11:00 AM with Licensed Practical Nurse (LPN), Staff D, she stated that she has been working for the facility for 7 months and works morning shift 7:00 AM to 3:00 PM. She explained that even if she is not assigned to a wing and sees a light on, the expectation is to go to the resident and assist. Staff D explained that if the assigned CNA is busy and a resident has a bowel movement, she will change the resident. She further expressed that it is not up to standard for a patient to wait 20 minutes to get changed, the expectation is to change them as soon as they are aware.		

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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 review of policy and procedure, observation, record review and interview, the facility failed to 1) obtain a physician's order for Oxygen Administration for 1 of 7 sampled residents observed for continuous Oxygen Therapy, Resident #128; and, 2) follow physician's orders for changing of Nebulizer tubing for 1 of 12 sampled residents observed for Nebulizer Treatments, Resident # 10. The findings included: 1) Review of the facility policy titled Oxygen Administration provided by the Director of Nursing (DON) revised October 2010 documented in the Policy Statement: Purpose---The purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation---1. Verify that there is a physician's order for this procedure. Review the physician's order or facility protocol for oxygen administration.Documentation---After completing the oxygen setup or adjustment, the following information should be recorded in the resident's medical record: 1. The date and time that the procedure was performed. 2. The name and title of the individual who performed the procedure. 3. The rate of oxygen flow, route, and rationale. 4. The frequency and duration of the treatment. 5.The reason for p.r.n. administration. 6. All assessment data obtained before, during and after the procedure. 7. How the resident tolerated the procedure.9. The signature and title of the person recording the data. Reporting---2. Report other information in accordance with facility policy and professional standards of practice. Resident #128 was re-admitted to the facility on [DATE] with diagnoses which included Respiratory Failure, Chronic Obstructive Pulmonary Disease (COPD), Diabetes Mellitus Type II and Dementia. She had a Brief Interview Mental (BIM) Status score of 9, indicating moderate cognitive impairment. On 12/15/25 at 9:55 AM and 3:45 PM, during an observational room tour, Resident #128 was observed with Oxygen infusing at three (3) liters per minute via nasal cannula through her Oxygen concentrator; with no current physician's order reviewed, in place. On 12/16/25 at 10:51 AM and 4:03 PM, Resident #128 was observed with Oxygen infusing at three (3) liters per minute via nasal cannula through her Oxygen concentrator; with no current physician's order reviewed, in place. On 12/17/25 at 11:29 AM, Resident #128 was still observed with Oxygen infusing at three (3) liters per minute via nasal cannula through her Oxygen concentrator; with no current physician's order reviewed, in place. Record review of Resident #128's Respiratory Care plan initiated and revised on 10/16/25 indicated Focus: Resident #128 has a potential for complications of respiratory distress related to a diagnosis of: Chronic Respiratory Failure, Congestive Heart Failure (CHF). Interventions:Oxygen saturations as ordered, Administer Oxygen as ordered, Vitals signs as ordered and as needed, Performs Lung Sounds/Respiratory Assessment as needed.Encourage Coughing and Deep Breathing and Observe signs and symptoms of respiratory infection, update physician if noted. Goals: Resident #128 will be able to maintain patent airway and will not exhibit signs of respiratory distress. And, Resident #128 will not observe signs and symptoms of respiratory distress thru next review date. The initial Physician's Order Sheet (POS) dated for 07/25/25 was reviewed; it only documented to, Monitor vital signs and oxygen saturation daily, and report abnormalities as necessary. Record review of the Physician's Pulmonary Progress Note dated 11/11/25 documented, Oxygen (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	continuous, keep Oxygen saturations > 92%. However, further record review conducted of the Physician's Order Sheet (POS) for the month of December 2025 revealed that there were no current physician's orders for Oxygen therapy administration parameters on file, for this resident, since her re-admission to the facility back in July 2025. Moreover, record review of both the Medication Administration Record (MAR) and of the Treatment Administration Record (TAR) further revealed that there were no current physician's orders for Oxygen therapy administration parameters on file, for this resident. During a brief interview conducted on 12/17/25 at 11:32 AM with the Resident #128's daughter, who had been visiting at the time, she was asked about Resident #128's oxygen use; the resident's daughter responded by saying that her mother had been using her Oxygen regularly, on a daily basis. On 12/17/25 at 11:47 AM an interview was conducted with Staff A, Registered Nurse (RN), Primary Care Nurse and Nurse Supervisor, for the 2nd floor, in which she was asked whether or not Resident #128 had been currently receiving Oxygen therapy. Staff A responded, yes, at three (3) liters. Staff A revealed that she was not aware of how long the resident had been receiving Oxygen. She also acknowledged that there was no current physician's order with parameters, on file for the Oxygen therapy. Staff A was unable to provide an explanation as to why there was no current physician order for the Oxygen. On 12/17/25 at 12:47 PM an interview was conducted with the Assistant Director of Nursing (ADON), in which she was also asked whether or not Resident # 128 was currently receiving Oxygen therapy. She responded by saying, yes, I think the oxygen is set at two (2) liters. She also revealed that she was not aware of exactly how long Resident #128 had been receiving Oxygen. A current physicians' order dated 12/17/25 for continuous Oxygen at two (2) liters/minute via nasal cannula every shift, was not written, until after surveyor inquisition. The DON recognized and acknowledged on 12/17/25 at 2:30 PM that a current physician's order should have been obtained, in a timely manner. The findings included: 2) Review of the facility's policy titled, Departmental (Respiratory Therapy) - Prevention of Infection, dated November 2021, included the following: The purpose of this procedure is to guide the prevention of infection associated with respiratory therapy tests and equipment, including ventilators, among residents and staff. Infection Control Considerations Related to Medication Nebulizers/Continuous Aerosol: 15. Take care not to contaminate internal nebulizer tubes. 16. Wipe the mouthpiece with damp paper towel or glass sponge. 17. Store the circuit in plastic bag, marked with date and resident's name, between uses. 19. Discard the administration set up every seven (7) days. Record review for Resident #10 revealed the resident was re-admitted to the facility on [DATE] with diagnoses that included: Acute and Chronic Respiratory Failure with Hypercapnia; Dementia; Adult Failure to Thrive; Sepsis, Unspecified Organism. Review of Resident #10's Physician's order dated 11/02/25 for Replace nebulizer tubing and mouthpiece weekly, every night shift every Sunday for Prophylaxis. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Section C of the Minimum Data Set (MDS) dated [DATE] revealed that Resident #10 had a Brief Interview for Mental Status (BIMS) of 00, which indicated that she was rarely understood. During the initial facility tour conducted on 12/15/25 at 9:40 AM, Resident #10 was observed in her bed dressed and her private aide was in the room. Further observation revealed Resident #10's nebulizer mouthpiece was lying on top of the bedside table, not contained in a plastic bag, and the nebulizer tubing was dated 12/01/25, photographic evidence obtained. Another observation was conducted on 12/17/25 at 10:00 AM for Resident #10's nebulizer mouthpiece, which was noted to have been placed in a plastic bag and stored in the bedside table drawer. In addition, the nebulizer tubing was observed to have been changed and was dated 12/15/25, photographic evidence obtained. Review of the December Treatment Administration Record (TAR) revealed nurses documented the nebulizer tubing was changed on 12/07/25 and 12/14/25. During an interview conducted on 12/18/25 at 9:25 AM with Staff G, Licensed Practical Nurse (LPN), who stated that she has been working for a few months. She stated that the oxygen and/or nebulizer tubing was to be changed once a week on Sundays. Staff G also stated If she does not see that the tubing has been changed, she will change it at that time. During an interview conducted on 12/18/25 at 10:21 AM with Staff F, Registered Nurse (RN), who stated she has worked at the facility for one and a half years as a floor nurse, unit manager, and every other weekend as the supervisor. She stated that the oxygen tubing is to be changed weekly or as needed and the tube is to be labeled and the nurse would document the tube has been changed in the TAR as per physician's orders. On 12/18/25 at 11:20 AM the Director of Nursing (DON) was made aware of the above concerns.		

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: 8Number of residents cited: 2Based on observations, interviews, record reviews and policy reviews, the facility failed to ensure residents were free of medication errors for 2 of 8 sampled residents (Residents #30 and #79), as evidenced by a medication error rate of 12.9% as a result of 4 errors made during 31 opportunities.The findings included: Review of the facility's policy titled, Administering Medications, undated, included the following: Medications shall be administered in a safe and timely manner, and as prescribed. Policy Interpretation and ImplementationThe Director of Nursing Services will supervise and direct all nursing personnel who administer medications and/or have related functions. Medications must be administered in accordance with the orders, including any required time frame.Medications must be administered within one (1) hour of the prescribed time, unless otherwise specified (for example, before and after meal orders). The individual administering the medication must check the label three (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.The individual administering the medication must initial the resident's MAR on the appropriate line after giving each medication and before administering the next ones.1) Record review for Resident #30 revealed that the resident was admitted to the facility on [DATE] with diagnoses that included: Chronic Obstructive Pulmonary Disease (COPD), Hypertension (HTN), Diverticulum of Esophagus, Acquired, Gastro-Esophageal Reflux Disease (GERD). Review of the physician orders included the following orders:Vitamin B-12 Oral Tablet 100 micrograms (mcg) to give 1 tablet by mouth one time a day for supplement.Ferrous Sulfate Tablet 325 (65 Fe) milligram (mg) to give 1 tablet by mouth one time a day for Supplement.Losartan Potassium Oral Tablet 25 mg to give 1 tablet by mouth one time a day for HTN.Sucralfate 1 Gram Tablet to give 1 tablet by mouth before meals for GERD (caused by stomach acid irritating the esophagus). During a medication administration observation conducted on 12/16/25 at 8:40 AM with Staff E, Registered Nurse (RN), who stated that this was her first day on her own after orientation, however, she was a Licensed Practical Nurse (LPN) at another facility and worked the night shift. Prior to dispensing the above medications for Resident #30, Staff E entered the resident's room and asked if he had finished with his breakfast. Resident #30 stated yes and the breakfast tray was noted to be in the room. She then returned to the medication cart and dispensed all the above medications. Staff E again entered the resident's room and administered all the medications to Resident #30, including Sucralfate 1 Gram, which was to be given before meals for GERD. 2) Record review for Resident #79 revealed that the resident was admitted to the facility on [DATE] with diagnoses that included: Multiple Fractures of Pelvis Without Disruption of Pelvic Ring, Subsequent Encounter for Fracture with Routine Healing, Dry Eye Syndrome of Unspecified Lacrimal Gland, Long Term (Current) Use of Aspirin, Parkinsonism, Hypertension.Review of the physician orders included the following orders:Carbidopa-Levodopa Oral Tablet 25-100 mg to give 2 tablets by mouth three times a day for Parkinson disease.Digoxin Oral Tablet 125 mcg to give 1 tablet by mouth one time a day for Atrial fibrillation.Eliquis Oral Tablet 2.5 mg (Apixaban) to give 1 tablet by mouth every 12 hours for Atrial fibrillation. Acetaminophen Tablet 325 mg to give 2 tablets orally every 6 hours as needed for Mild Pain Not to exceed 3gm/ 3000mg in 24 hours.Aspirin Oral Tablet Chewable 81 mg to give 1 tablet by mouth one time a day for Deep Vein Thrombosis (DVT) prevention.Calcium 600+D3 Oral Tablet 600-5 mg-mcg to give 1 tablet by mouth one time a day for hypocalcemia. Carboxymethylcellulose Sodium Ophthalmic Solution 0.5 % to instill 1 drop in both eyes two times a day for Dry Eyes.On 12/16/25 at 8:45 AM, a medication administration observation was conducted with Staff E, RN. She dispensed the following medications for Resident #79: Carbidopa-Levodopa 25-100 mg 2 tablets; Digoxin 125 mcg tablet; Eliquis 2.5 mg tablet; and Acetaminophen 325 mg 2 tablets (Resident #79 requested pain medication). Staff E then stated that Resident #79 gets his medications crushed and these are all his morning medications. Verification of the physician orders (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and reconciliation of the medications administered to Resident #79, revealed that Staff E did not administer the following three medications that were scheduled to be given in the morning: Carboxymethylcellulose Sodium Ophthalmic Solution 0.5 % drops, Calcium 600+D3 600-5 mg-mcg tablet, and Aspirin Chewable 81 mg tablet. Review of Resident #79's Medication Administration Record (MAR) revealed that Staff E documented that she administered all of the medications that were scheduled to be given in the morning of 12/16/25. During an interview conducted on 12/16/25 at 8:54 AM, with Staff E, RN, who stated that she reviews the orders on the computer and the ones on the medication bingo sheet. She was asked to review the order for Resident #30's Sucralfate 1 Gram. She stated that the residents were new to her and did not realize that the medication was to be given prior to breakfast. During an interview conducted on 12/16/25 at 10:25 AM with the Director of Nursing (DON), who was told of the medication errors encountered during medication pass observations. She stated that Staff E came in today to cover for a nurse that called out and that she was to be mentored by Staff F, RN. The DON stated Staff E just finished her orientation but has not done medication pass with her yet. She acknowledged that Staff E should not have been administering medications on her own.		