Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11942934	A. BUILDING: _____ B. WING _____	08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE W ASSISTED LIVING AT POMPANO BEACH	295 SW 4TH AVENUE POMPANO BEACH, FL 33060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced licensure Complaint (#2021016018, #2022004670, #2022005459, #2022006999 and #2022011295) survey was conducted on . . . . . and . . . . . at The W Assisted Living at Pompano Beach. The facility had a deficiency related to Complaint #2021016018 and an unrelated deficiency identified related to Complaint #2022005459 at the time of the survey.	A 000		
A 054	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known ˘ the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors.	A 054		

AHCA Form 3020-0001

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

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A 054	Continued From page 1 (c) For medications that serve as chemical , the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on interview and record review the facility failed to ensure the Medication Observation Records (MOR) were available for review for 1 of 2 sampled residents, specifically Resident #2. The findings included: In an interview conducted with the Administrator on at 10:21 AM, a request was made for the facility file and documents for Resident #2, which the Administrator provided. Review of Resident #2's file revealed the MORs were missing, specifically for , , and . In an interview conducted with the Administrator, he stated they may be in the closed files and would have someone look for them. The requested information was not provided the day of the request. In an interview conducted with Medication Technician/Unit Manager of the Memory Care Unit on at 9:54 AM, a request was made for Resident #2's , and MORs. The Unit Manager looked in the cabinets in his office and was not able to locate them. The Unit Manager made a call to the front office, and was informed they were in a folder up front. The Unit Manager and this Surveyor went to the closed files located in a locked storage room, but the Unit Manager was unable to locate the documents. The Unit Manager and this Surveyor	A 054		

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A 054	Continued From page 2 went to the Nurses' station at the front of the facility where an additional search was conducted, but the documents could not be located. The requested information was not provided during the survey. On . . . . . at 3:03 PM, during the exit conference with the Administrator, he acknowledged the MORs for Resident #2 were not available for review. Class III	A 054		
A 092	59A-36.012(1) FAC Food Service - General Responsibilities (1) GENERAL RESPONSIBILITIES. When food service is provided by the facility, the administrator, or an individual designated in writing by the administrator, must be responsible for total food services and the day-to-day supervision of food services staff. In addition, the following requirements apply: (a) If the designee is an individual who has not completed an approved assisted living facility core training course, such individual must complete the food and nutrition services module of the core training course before assuming responsibility for the facility's food service. The designee is not subject to the 1 hour in-service training in safe food handling practices. (b) If the designee is a certified food manager, certified dietary manager, registered or licensed dietitian, dietetic registered technician, or health department sanitarian, the designee is exempt from the requirement to complete the food and nutrition services module of the core training course before assuming responsibility for the facility's food service as required in paragraph (1)	A 092		

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A 092	Continued From page 3 (a) of this rule. (c) An administrator or designee must perform his or her duties in a safe and sanitary manner. (d) An administrator or designee must provide regular meals that meet the nutritional needs of residents, and therapeutic diets as ordered by the resident's health care provider for residents who require special diets. (e) An administrator or designee must comply with the food service continuing education requirements specified in rule 59A-36.011, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure food was handled and prepared in a manner to prevent the potential for food borne illness, as evidence by observation of the dietary staff preparing and distributing food in an unsanitary manner. The findings included: On . . . . . at 11:46 AM, an observation in the kitchen revealed the Cook not wearing gloves while preparing sandwiches. After this surveyor had been standing there for about 3 minutes, he put on gloves. Further observation revealed the kitchen floor was dirty with food debris and dirty dishes were sitting on the countertop in the food preparation area. (Photographic evidence obtained.) On . . . . at 12:31 PM, an observation in the kitchen revealed the Cook and Supervisor preparing chicken salad sandwiches without wearing gloves. On . . . . . at 12:40 PM, during a tour of the Memory Care Unit accompanied by the Kitchen Manager, an Aide was observed to dip the same Styrofoam cup into a pitcher of water and ice and	A 092		

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A 092	Continued From page 4 then pour it into each cup of soup. She stated they did this so that the soup would not be too hot for the residents. On . . . . . at 12:41, an inquiry was made to the Dietary Supervisor about this technique, and the potential for the water diluting the nutritional value of the soup and the inconsistency of the amount of water and ice going into each cup, to which the Dietary Supervisor had no comment. On at 12:43 PM, further lunch meal service observation was made of the lunch meals served on paper plates stacked on top of each other on a cart for delivery to the unit. (Photographic evidence obtained.) In an interview conducted with the Kitchen Manager, he stated they are waiting for the kitchen renovations to be completed and then everyone would be eating in the dining room with the exception of the Memory Care residents, then they would revert . . . to using real dishes. An explanation for using paper plates versus glass dishes, and stacking the paper plates on the cart for delivery was not clearly explained. On at 1:11 PM, observation was made of the Kitchen Supervisor scooping coleslaw from a carton without wearing gloves. (Photographic evidence obtained of the Kitchen Supervisor holding the plate without wearing gloves.) On . . . . . at 9:40 AM, an observation was made of a Dietary Aide not wearing a hair net in the kitchen. After this Surveyor donned a hair net prior to entering the kitchen, the Dietary Aide proceeded to also apply a hair net. On at 11:45 AM, a further kitchen observation was made of the lunch meal	A 092		

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A 092	Continued From page 5 preparation revealing the Cook was again not wearing gloves in the food preparation area despite observations conducted by this Surveyor the day prior. Class III	A 092		