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
	AL11965625	A. BUILDING: _____ B. WING _____	08/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACTIVE SENIOR LIVING RESIDENCE	9057 NW 57TH STREET TAMARAC, FL 33351

(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 Relicensure, Complaint (#2022000413 and #2022012042) and Generator Monitoring survey was conducted on at Active Senior Living Residence. The facility had a deficiency identified at the time of the survey.	A 000		
A 036	59A-36.007(10) CONTROL PROCEDURES (10) CONTROL PROCEDURES. Facilities must provide services in a manner that reduces the risk of transmission of . (a) The facility must implement a hygiene program before and after the provision of personal services to residents whenever there is an expectation of possible exposure to materials or hygiene may include the use of -based rubs, handwash, or handwashing with soap and water. (b) Standard precautions must be used when there is an exposure to transmissible agents in , nonintact skin, and mucuous during the provision of personal services. Standard precautions include: hygiene, and dependent upon the exposure, use of gloves, gown, mask, protection, or a shield. (c) The facility must clean and reusable medical equipment and communal assistive devices that have been designed for use by multiple residents before and after each use according to the manufacturer's recommendations. This Statute or Rule is not met as evidenced by: Based on observation and interview the facility failed to provide services in a manner that	A 036		

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A 036	Continued From page 1 reduces the risk of cross contamination as observed during a medication pass for 1 of 3 sampled residents, Resident #11, observed being provided assistance with the self-administration of medications. The findings included: During an observation of the medication pass on at 12:10 PM, Staff F Medication Technician (MT), who was assisting with the self-administration of an oral medication for Resident #11, while preparing the oral medication to be dispensed into a medication cup, dropped the medication tablet on top of the medication cart. Staff F MT proceeded to pick up the tablet and placed it in the medication cup to be administered to Resident #11. During this observation on at 12:10 PM, an interview was conducted with Staff F MT who stated he does not remember when he cleaned or sanitized the medication cart. Staff F MT acknowledged dropping the oral medication on top of the medication cart and placing it into the medication cup to be administered rather than disposing of it and obtaining another oral medication dose. On at 4:05 PM, an interview was conducted with the Administrator who revealed Staff F MT did not clean the medication cart and thus picking up the dropped medication and placing it into the medication cup for administration to Resident #11 was an control issue. The Administrator acknowledged the observation. Class III	A 036		