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 _____	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RESIDENCE AT POMPANO BEACH LLC	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 Complaint investigation, complaint number 2026007238, was conducted at The Residence at Pompano Beach LLC from - . The facility had deficiencies at the time of the survey.	A 000		
A 162	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. , 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance , 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the resident's health care practioner and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 or the health care practitioner's medical examination form described in Rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, , or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to Rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in	A 162		

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A 162	Continued From page 1 paragraph 59A-36.007(1)(f), F.A.C. (f) A ˘ record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their ˘ recorded semi-annually. This subsection does not apply to residents who are receiving licensed hospice services when such residents, their representatives, or their physicians request in writing that ˘ not be taken. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to Rule 59A-36.008, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in Rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in Section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in Section 429.27, F.S. (l) If the resident is an recipient, a copy of the Department of Children and Families form Alternate Care Certification for , , ( ), CF-ES 1006,	A 162		

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A 162	Continued From page 2 2005, which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No =Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the , , of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in Rule 59A-36.006, F.A.C. (o) The resident's , DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to a log listing the names of residents participating in this arrangement. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 59A-36.020,	A 162		

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A 162	Continued From page 3 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to maintain accurate emergency contact information. As evidenced by the failure to obtain, verify and document accurate name, address and phone number for Resident #1's next of kin emergency notification. The findings include: Review of Resident #1's medical record indicated the resident was admitted to the facility on . Review of the facility demographic sheet for Resident #1 indicated under contacts, a first name, no last name yet identified as "sister" and a telephone number, XXX-XXX-9547. Review of Resident #1's admission contract paperwork dated , which was provided by the family to the surveyor for review, revealed a mark/ line was made on the signature lines and had resident initials. Further review revealed under page 2 "emergency contact" a first and last name of Resident#1's sister, her address and phone number, XXX-XXX-4778. (see photographic evidence) Review of Resident #1's admission contract paperwork dated which was provided by the facility for review revealed the resident signed his full name to the admission documents. Further review indicated under page 2 "emergency contact" with a first name and no last name, identified as "sister" with a telephone number, XXX-XXX-9547. (This number was different from the number on the admission contract dated). (see photographic	A 162		

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A 162	Continued From page 4 evidence) Further review of Resident#1's medical record indicated the resident was assessed on admission to be oriented to person only and required assistance with all Activities of Daily Living (ADL) except eating. Resident#1 had medical history including , , with , , features, , , and Review of facility progress notes for Resident#1 on indicated staff reported the resident was declining mentally and physically and not eating. The health care provider was notified and recommended that Resident#1 be admitted to hospice services. Review of Resident #1's "Hospice Provider Admission Consent "dated revealed a signature representing as a "responsible person or legal guardian" signature. (see photographic evidence). In an interview with the Social Worker on at 9:35 AM she stated she is employed with a "health care proxy" service company. She stated she is hired when a patient/resident is unable to make their own medical decisions and there is no family member or legal representative identified/found. She stated she recalled that Resident#1 had lived in the facility for approximately two years and had no family involvement in his care, had no visitation and phone contact with family was unsuccessful after numerous attempts. She stated the hospice provider contacted her after the unsuccessful attempts to locate any family of the resident. She stated she signed for Resident #1 to be admitted	A 162		

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A 162	Continued From page 5 to hospice services. Review of facility progress notes for Resident#1 on 4:31 PM indicated the resident was found unresponsive by facility staff and hospice was called. The hospice nurse arrives at the facility and pronounces Resident#1 . The note indicated the "resident's family listed in the file could not be reached and her whereabouts unknown. The note further states that the resident resided in the facility with no family involvement and no visits recorded and no response to calls made by the facility." In an interview with Resident #1's family on at 11:56 AM she stated that she was Resident's #1's family, next of kin and had not been notified of the resident's on . She stated that she found out about his when an email was received indicating suspension of Resident #1's Medicaid funds. The family member confirmed her phone number as correct on the admission contract dated . Review of the facility records indicated the emergency number listed on the facility's demographic sheet and contract forms dated was incorrect. In an interview with the Administrator on at 10:20AM, she stated that the resident had , mental health behaviors and had very limited verbal communication. She stated that Resident#1 was been admitted for approximately two years and had no family contact that she was aware of. She stated that Resident#1 began to decline, and the health care provider recommended placing the resident on hospice services. She stated that the facility had made numerous calls to the phone number noted on the resident's sheet / admission sheet. She	A 162		

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A 162	Continued From page 6 stated that messages were left with no response. She stated the family never visited the resident and she was unaware of any calls for the resident. She stated the resident was not capable to call anyone and never asked to speak with his family. The Administrator stated the hospice provider also made attempts to contact the family and were unsuccessful, so a healthcare proxy was hired to admit the resident to hospice services. The Administrator stated that she had no documentation of the facility attempts to contact Resident #1's family. She stated the first time she spoke with Resident #1's family member since his admission was when the family member called her after his was identified. The Administrator stated the facility believed that Resident#1 had no family or representatives. She stated she had no documentation of any management attempts to contact Resident #1's family with a change in medical condition of the resident. Class III	A 162		