STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105298	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FT Lauderdale Health & Rehabilitation Center	2000 East Commercial Blvd Fort Lauderdale, FL 33308

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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38349 Based on review of policy and procedure, observation, interview and record review, the facility failed to ensure that the MDS (Minimum Data Set) Resident Comprehensive Assessment was completed in a timely manner for 6 of 42 sampled residents reviewed for MDS Assessments, (Resident #77, Resident #40, Resident #24, Resident #33, Resident #39, and Resident #23). The findings included: Review of the facility policy and procedure titled, MDS Completion and Submission Timeframes revised July 2017 and provided by the Director of Nursing (DON) documented in the Policy Statement: Our facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes. Policy Interpretation and Implementation 1. The Assessment Coordinator or designee is responsible for ensuring that resident assessments are submitted to CMS' QIES Assessment Submission and Processing (ASAP) system in accordance with current federal and state guidelines. 2. Timeframes for completion and submission of assessment is based on the current requirements published in the Resident Assessment Instrument Manual. 3. Submission of MDS records to the QIES ASAP is electronic. A hard copy of each record submitted is maintained in the resident's clinical record for a period of fifteen (15) months from the date submitted. Review of the facility policy and procedure revised December 2002, titled Resident Assessment Instrument (RAI) Assessment Scheule Summary, provided by the DON documented for Record Type: Quarterly .no later than 14 days after the Assessment Reference Date (ARD) 1) Resident #77 was admitted to the facility on [DATE] with diagnoses which included Unilateral Primary Osteoarthritis, Right Knee, Hypertension and Dementia. She had a Brief Interview Mental Status (BIM) score of 5, indicating severe cognitive impairment. Record review revealed that Resident #77's Quarterly MDS ARD was 08/03/24. The due date for the Assessment to have been completed was 08/17/24. Staff D, lead full-time RN, MDS Coordinator, had not electronically signed the MDS Comprehensive Assessment as completed until Saturday 09/14/24, approximately four (4) weeks after the ARD date. 2) Resident #40 was admitted to the facility on [DATE] with diagnoses which included Chronic Obstructive Pulmonary Disease, Alzheimer's Disease and Atherosclerotic Heart Disease. She had a Brief Interview Mental Status (BIM) score of 14, indicating intact cognition. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105298	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024
NAME OF PROVIDER OR SUPPLIER: FT Lauderdale Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 2000 East Commercial Blvd Fort Lauderdale, FL 33308	

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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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review revealed that Resident #40's Quarterly MDS ARD was 08/10/24. The due date for the Assessment to have been completed was 08/24/24. Staff D had not electronically signed the collective MDS Comprehensive Assessment as completed until Saturday 09/14/24, approximately three (3) weeks after the ARD date. 3) Resident #24 was readmitted to the facility on [DATE] with diagnoses which included Urinary Tract Infection, Diabetes Mellitus Type II, Epilepsy, Myasthenia Gravis and Hypertensive Chronic Kidney Disease. She had a Brief Interview Mental Status (BIM) score of 13, indicating intact cognition. Record review revealed that Resident #24's Quarterly MDS ARD was 08/10/24. The due date for the Assessment to have been completed was 08/24/24. Staff D had not electronically signed the collective MDS Comprehensive Assessment as completed until Saturday 09/14/24, approximately three (3) weeks after the ARD date. 4) Resident #33 was admitted to the facility on [DATE] with diagnoses which included Degenerative Disease of Nervous System, Paraplegia, Hypertension and Atherosclerotic Heart Disease. He had a Brief Interview Mental Status (BIM) score of 3, indicating severe cognitive impairment. Record review revealed that Resident #33's Quarterly MDS ARD was: 08/03/24. The due date for the Assessment to have been completed was 08/17/24. Staff D had not electronically signed the collective MDS Comprehensive Assessment as completed until Saturday 09/14/24, approximately four (4) weeks after the ARD date. 5) Resident #39 was readmitted to the facility on [DATE] with diagnoses which included Major Depressive Disorder, Schizoaffective Disorder, Anxiety Disorder, Encephalopathy and Hypertension. She had a Brief Interview Mental Status (BIM) score of 1, indicating severe cognitive impairment. Record review revealed that Resident #39's Quarterly MDS ARD was: 08/03/24. The due date for the Assessment to have been completed was 08/17/24. Staff D had not electronically signed the collective MDS Comprehensive Assessment as completed until Saturday 09/14/24, approximately three (3) weeks after the ARD date. 6) Resident #23 was readmitted to the facility on [DATE] with diagnoses which included Calculus of Gallbladder with Chronic Cholecystitis without Obstruction, Major Depressive Disorder, Psychotic Disorder with Hallucinations, Alzheimer's Disease and Hypertensive Heart and Chronic Kidney Disease with Heart Failure. She had a Brief Interview Mental Status (BIM) score of 3, indicating severe cognitive impairment. Record review revealed that Resident #23's Quarterly MDS ARD was 08/10/24. The due date for the Assessment to have been completed was 08/17/24. Staff D had not electronically signed the collective MDS Comprehensive Assessment as completed until Saturday 09/14/24, approximately four (4) weeks after the ARD date. A side-by-side record review was conducted with Staff D, of the six (6) MDS Quarterly Comprehensive Resident Assessments for the month of August 2024, in which it was noted that for all six (6) Assessments, Staff E, RN, MDS Coordinator, was assigned to complete. (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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further record review indicates that none of the above listed six (6) collective MDS Quarterly Resident Comprehensive Assessment types had been completed in a timely manner, until at least three (3) or four (4) weeks later, after their individual ARD dates. During a simultaneous interview conducted on 09/18/24 at 10:37 AM with Staff E and Staff D, it was stated that the Social Services Director, had not completed any of her six (6) Resident Social Work Assessment sections until Saturday 09/14/24. Additionally, both Staff E and Staff D both acknowledged that the collective MDS Resident Comprehensive Assessments needed to be completed in a timely manner to ensure that the Residents are accurately, timely assessed and evaluated, in order to carry out the correct and appropriate plan of care. On 09/18/24 at 10:42 AM an interview was conducted with the Social Services Director, who indicated that she had not completed any of the six (6) MDS Resident Social Work Assessment sections until Saturday 09/14/24. The Social Services Director also indicated that she was not able to provide any specific reasoning as to why this had not been done. The DON further acknowledged that on 09/18/24 at 11:37 AM, that the collective MDS Resident Comprehensive Assessments should have been completed in a timely manner by all facility departments. This was not done.

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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 0687

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide appropriate foot care.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 36057

Based on observations, interviews and record review, the facility failed to ensure residents received foot care (Podiatry) in a timely manner for 2 of 2 sampled residents reviewed for Podiatry Care (Resident #4 and #130).

The findings included:

1) Review of Resident #4's clinical record documented an admission to the facility on [DATE] with no readmissions. The resident's diagnoses included Heart Failure, Generalized Anxiety Disorder, Dementia, Peripheral Vascular Disease, Venous Insufficiency (Chronic) Muscle Weakness and Difficulty in Walking.

Review of Resident #4's Minimum Data Set (MDS) quarterly assessment dated [DATE] documented a Brief Interview of the Mental Status (BIMS) score of 10, indicating that the resident had moderate cognition impairment. The assessment documented under Functional Abilities and Goals that the resident was dependent on the staff to complete the activities of daily living including putting footwear on, dressing and bathing.

Review of Resident #4's care plan titled [Resident Name] exhibits the following behaviors: resists cares and will refuse to shower at times, initiated on 05/07/24. Interventions to include, to anticipate care needs and provide them before resident becomes overly stressed. The Care Plan did not address refusal of foot care.

Review of Resident #4's physician orders dated 10/31/24 documented May consult podiatry .services as needed.

Review of Resident #4's clinical record revealed the last documented Podiatry consult was dated 02/20/24.

On 09/16/24 at 11:18 AM, observation revealed Resident #4 in bed with her toes uncovered. Observation revealed Resident #4's right and left foot with elongated toenails. Subsequently, an interview was conducted with Resident #4 who stated she was not sure if she had seen a foot doctor or not. The resident was asked permission to take a picture of her toenails to discuss the care with the Director of Nursing, the resident agreed.

On 09/17/24 at 9:24 AM, observation revealed Resident #4 out of bed sitting in a wheelchair, well dressed, groomed and wearing tennis shoes.

On 09/17/24 at 2:32 PM, an interview was conducted with Staff B, Certified Nursing Assistant (CNA) assigned to Resident #4. Staff B stated she gave a full bath in bed to the resident. Staff B was asked if she report anything related to the care of Resident #4 to the nurse, like her nails, skin or toenails, and replied she had nothing to report to the nurse. Staff B added sometimes the resident did not want her to cut the nails. Staff B was asked how were Resident #4's toenails and replied, they are okay. Staff B confirmed the resident was dependent on the staff for her activities of daily living and can only feed herself.

(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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/17/24 at 2:51 PM, a side-by-side observations of Resident #4's toenails was conducted with Staff A, Licensed Practical Nurse (LPN) and Staff B, CNA. Staff B stated Resident #4's toenails needed to be done. Staff A reported that Resident #4 fights and scratches the staff, Staff B was made aware that there was no written documentation related to Resident #4 refusing toenail care. Subsequently, a side-by-side review of the Podiatry consult log binder was conducted with Staff A. The review revealed Resident #4 was not listed to be seen by the Podiatrist. On 09/17/24 at 2:55 PM, an interview was conducted with the facility's Podiatrist who stated he comes to the facility twice a week. The Podiatrist stated the visit frequency depends on the resident's insurance and that most of them can be seen every 60 days. The Podiatrist was made aware of the status of Resident #4's toenails. On 09/17/24 at approximately 3:15 PM, observation revealed the Podiatrist ready to do Resident #4's, toenail care and stated her nails were long. On 09/19/24 at 9:50 AM, an interview was conducted with the Unit Manager who stated each floor has a Podiatrist book for the staff to log in residents who needs to be seen. The Unit Manager was apprised that Resident #4 was not on the current list to be seen. On 09/19/24 at 9:52 AM, a joint interview was conducted with the Regional Nurse and the Unit Manager, and they were apprised of Resident #4's elongated toenails. (Photographic evidence showed). 2) Review of Resident #130's clinical record documented an admission to the facility on [DATE] with no readmissions. The resident's diagnoses included Pneumonia, Restless Legs Syndrome, Major Depressive Disorder, Convulsions, Difficulty in Walking, Muscle Weakness, Sepsis, Intraspinal Abscess and Granuloma, Osteomyelitis of Vertebra, and Pressure Ulcer of Sacral Region. Review of Resident #130's MDS assessment dated [DATE] documented a BIMS score of 15, indicating that the resident had no cognition impairment. The assessment documented under Functional Abilities and Goals that the resident was dependent on the staff for most of his Activities of Daily Living (ADLs) including bathing and putting on footwear. Review of Resident #130's care plans record revealed no care plan related to foot care refusal. Review of Resident #130's physician orders dated 06/18/24 documented May consult podiatry .services as needed. Review of Resident #130's clinical record revealed a lack of a written Podiatry consult. On 09/16/24 at 11:40 AM, an interview was conducted with Resident #130 who stated he has been in the facility for 3 months and had not seen a Podiatrist. The resident agreed for the surveyor to look at his toenails. The Resident's private duty aide was in the room and removed the resident's non-skid socks. Observation revealed Resident #130's right and left foot toenails were elongated. The resident agreed with further investigation related to the elongated toenails. On 09/17/24 at 2:39 PM, an interview was conducted with Staff B, CNA who stated Resident #130's toenails were okay and did not need to tell the nurse anything about his toenails. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/17/24 at 2:47 PM, a side-by-side observation of Resident #130's toenails was conducted Staff A, LPN and Staff B, CNA. Staff A stated that the foot doctor comes in 2 to times a week and she will have him see Resident #130. During the observation Resident # 130 stated he did not like people to see his toenails but will allow the foot doctor in. On 09/17/24 at 2:55 PM, an interview was conducted with the Podiatrist who asked if Resident #130 was new and was informed the resident had been in the facility since June 2024. The Podiatrist stated he will see the resident today. On 09/19/24 at 9:51 AM, an interview was conducted with the Unit Manager who stated each floor has a Podiatrist book for the staff to log in the residents who needed to be seen. The Unit Manager was apprised that Resident #130 was not on the list to be seen. On 09/19/24 09:52 AM, a joint interview was conducted with the Regional Nurse and Unit Manager, and they were apprised of Resident #130's elongated toenails.

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 01948 Based on observation, interview, and record review, it was determined that the approved menu and portion sizes were not followed for 137 of 145 facility residents who eat by mouth. The findings included: During the review of the approved menu for the lunch meal of 09/18/24, it was noted the following entrees were documented to be served: Regular Diet: Shrimp Fried Rice (4 ounces of Shrimp) Mechanical Soft Diet: Ground Sauteed Shrimp (4 ounces) Pureed Diet: Pureed Sauteed Shrimp (4 ounces) Consistent Carbohydrate Diet: Shrimp Fried Rice (4 ounces of Shrimp) No Added Salt Diet: Shrimp Fired Rice (4 ounces of Shrimp) Renal Diet: Salisbury Steak (4 ounces beef) During the observation of the lunch tray line in the main kitchen on 09/18/24 at 12:15 PM, it was noted that Breaded Popcorn Shrimp was being served over cooked rice for the entrees. Interview with the Certified Dietary Manager (CDM) at the time of the observation was noted to state that plain non-breaded Shrimp was not delivered, and the Breaded Popcorn Shrimp was substituted. During the tray line observation, a random portion of the Breaded Popcorn Shrimp was weighed using the facility's calibrated food portion scale. The weighing was performed by the CDM, and an average Breaded Popcorn Shrimp was recorded at 4.5 ounces. Following the weighing a review of the manufacturer's nutrient analysis (Nutrient Facts) documented that a 4-ounce portion of the breaded Shrimp provided only 15 grams of Protein. It was further discussed with the CDM and Corporate Food service Director that an 8-ounce portion of the Breaded Shrimp was required to ensure that 4 ounces of Shrimp protein was being provided in each resident portion. The surveyor provided the mathematical equation and agreed that the menu portion for the Shrimp (4 ounces Protein) was not being provided. A random portion of the Breaded Salisbury Steak (entree alternate) was also requested by the surveyor to be weighed via the facility's food portion scale, and it was noted that the beef entree was recorded at only 2.5 ounces. It was again discussed with the CDM and Corporate Food Service Director that only 19 grams of Protein was being served in the entree. It was further reviewed that a 5-ounce portion of the breaded Salisbury Steak should have been served to ensure that a 4-ounce protein (28 grams) was being served to facility residents. It was further discussed that the facility had purchased an insufficient portion of the steak (3 ounce per steak patty) and should have purchased a 5-ounce steak patty to ensure that a cooked 4-ounce portion of the beef patty was being served, as per the approved menu. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Following the lunch observation conducted in the main kitchen on 09/18/24 the findings were discussed with the facility's Administrator and confirmed the surveyor's findings.

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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 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36057 Based on record review, observations and interviews, the facility failed to obtain a variety of Gluten Free products to honor 1 of 1 sampled resident reviewed for Therapeutic Gluten Free Modified Diet (Resident #130). The findings included: Review of Resident #130's clinical record documented an admission to the facility on [DATE] with no readmissions. The resident's diagnoses included Celiac Disease, Vitamin Deficiency, Muscle Weakness, Sepsis, Osteomyelitis of Vertebra, and Pressure Ulcer of Sacral Region. Review of Resident #130's Minimum Data Set assessment dated [DATE] documented a Brief Interview Mental Status score of 15, indicating that the resident had no cognition impairment. The assessment documented under Functional Abilities and Goals that the resident was dependent on the staff for most of his Activities of Daily Living (ADLs). Review of Resident #130's care plan titled [Resident name] is at risk for an alteration in: nutrition and/or hydration related to: receives therapeutic diet-gluten free, has variable, oral intake, Celiac Disease .Anemia, impaired skin integrity, low (body mass index) BMI with 5% loss 6/24-7/24. Frequent preference changes for food and supplements. The care plan was initiated on 06/20/24; Interventions included: Provide diet as ordered. Offer and provide alternate as needed. Review of Resident #130's clinical record documented a physician order dated 06/19/24 for a Regular Diet Modified for Gluten Free. Review of Resident #130's Nutrition/Dietary Note dated 06/20/24 documented .Gluten Free menu style to be provided . Review of Resident #130's Nutrition/Dietary Note dated 07/14/24 documented .care plan meeting held with family and resident and food preferences were updated . Review of Resident #130's Dietary Progress Note dated 09/11/24 documented .food preferences routinely updated . On 09/16/24 at 11:45 AM, an interview was conducted with Resident #130 who stated he had Celiac Disease for 3 years and the facility promised him that they will provide a Gluten Free diet for him. The resident stated he was only getting Gluten Free bread and that he had to order out to get his special diet. The resident added it is frustrating because he asked for other Gluten Free products beside bread, and they said they don't have it. The resident added that his family and himself met with the Dietitian and promises were made that they will have Gluten Free meals for him. On 09/16/24 at 12:57 PM, during dining observation, Resident #130's meal ticket documented Early Tray-Regular-Gluten Free Diet .Gluten Free Bread .Allergies: Gluten. (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 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/17/24 at 9:25 AM, an interview was conducted with Resident #130 who stated he had an Early tray because if he could not eat what they brought in, he would order out. The resident stated he got Gluten Free bread for breakfast. On 09/18/24 at 9:46 AM, a joint interview was conducted with the facility Registered Dietitian (RD) and Agency for Health Care Administration (AHCA) Registered Dietitian Surveyor. The RD stated Resident #130 was on a Gluten Free modified diet due to Celiac Disease, and added the resident had a history of extreme weight loss. The RD was asked what Gluten Free products the facility had in house for Resident #130 and replied they buy Gluten Free bread, pasta and added she will check for what else they had in house. The RD was apprised about Resident #130 stating he would like to have pasta, and the facility did not have it and that he was ordering food out because of limited products as only Gluten Free bread. The RD stated they had met with the resident and discussed his preferences, added the resident prefers to order out and in the last 30 days had not heard concerns or complaints related to his diet. The RD stated that she thought the preferences/concerns were rectified and added that the Certified Dietary Manager (CDM) had worked on multiple preferences for Resident #130. On 09/18/24 at 9:56 AM, a tour to the kitchen was conducted with the RD, the CDM, the Food Service Supervisor (FSS), and AHCA RD surveyor. The CDM was asked what Gluten Free products they had available for Resident #130 and stated bread. The FSS was asked if she had Gluten Free pasta or flour in-house and stated she did not. The CDM stated he could not order Gluten Free flour or pasta because it was not on the ordering list. The CDM provided the facility's order guide which did not included Gluten Free flour. The RD provided the facility's Diet Manual-Gluten Free Diet sheet that documented if gluten free restricted is ordered-use resident preferences to design menu. On 09/18/24 at 10:14 AM, an interview was conducted with Resident #130 who stated that there was a cake on his tray, sometime this week and he did not eat it. Resident #30 was asked why he wrote order out on the menu selection for 09/19/24 dinner, 09/21/24 lunch and dinner. He stated because there was nothing Gluten Free for him to order. The resident added that the Kitchen Manager told him that they put wheat in the soups and bread crumbs on the meatballs, so he could not have neither. He added he was afraid he will eat something that was not Gluten Free, so he had to order out. The 09/19/24 dinner menu documented Corn Chowder, Alternative choice-Hamburger on a Bun . The 09/21/24 lunch menu documented Crispy chicken . dinner menu-chicken noodle soup, tuna salad on wheat-alternative choice-beef meatballs . On 09/18/24 at 10:34 AM, an interview was conducted with the RD who stated she spoke with Resident #130, and he would like to have Gluten Free pasta. The RD stated we can accommodate him better and do a better job. The RD further stated they can have small, prepared meals for the resident. The RD stated they will purchase additional gluten free items for Resident # 130. On 09/19/24 at 11:19 AM, an interview was conducted with the RD who stated that on 07/10/24, Resident # 130 and his sister complained of limited options of Gluten Free products and on 07/16/24, the FSS met with the resident and updated the preferences. The RD added the FSS was talking with the resident every week. The RD was asked if the FSS documented her weekly visit with Resident #130 and stated she did not. The RD stated the FSS note dated 07/16/24 did not document details of the resident's preferences update.

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F 0812

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.

01948

Based on observation, interview, and record review, it was determined that, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety for 123 of the 145 facility residents, who eat food by mouth.

The findings included:

1) During the initial kitchen/food service observation tour conducted on 09/16/24 at 9 AM and accompanied with the facility Certified Dietary Manager (CDM), the following were noted:

(a) Observation of the food preparation sink noted that two 10-pound plastic sleeves of ground beef were thawing in a large pan that had running water flowing into the pan. Further observation noted that the cold-water faucet was tuned on full capacity, however the water felt lukewarm to the touch. At the request of the surveyor, the temperature testing of the running water was taken with the facility's calibrated digital food thermometer. The test noted that the temperature of the running water coming from the top of the cold-water faucet was recorded at 80.9 degrees Fahrenheit. A second testing recorded 5 minutes later was again recorded at 80.9 degrees F (Fahrenheit). An interview conducted with the CDM by the surveyor at the time of the second testing revealed that the regulatory requirement for cold water thawing of potentially hazardous food was 70 degrees F or below. It was further discussed with the CDM that the facility's cold-water temperature was approximately 11 degrees F over the regulatory requirement and that continued thawing (time & temperature) would result in food borne illness. The surveyor requested that the practice of thawing meats in cold water be halted immediately and to thaw in the alternate thawing procedure in the refrigerator at 41 degrees F of below for a maximum of 3-days. The surveyor also requested that the thawed ground beef be discarded and not utilized for the residents.

(Photographic Evidence Obtained).

(b) Review of the facility's Policy & Procedure: for the Dishwashing Machine Use/Cleaning, noted the following:

#10 - De-lime Dish machine once a month. If build up occurs increase the de-liming until dish machine is satisfactory. Run rubber skirts assemblies through the dish machine daily to maintain clean and debris free.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105298	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FT Lauderdale Health & Rehabilitation Center	2000 East Commercial Blvd Fort Lauderdale, FL 33308

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 - Few	During the observation of the dish machine, it was noted that the high temperature machine contained 3 separation curtains (entrance, internal, and exit) within the interior of the machine. At the request of the surveyor, the curtains were removed and observed. The observation noted that that all 3 curtains had a heavy build-up of decayed/rotting food matter. It was also noted that there was a heavy build-up of lime (hard water build-up) on the curtains and the stainless-steel dish run that exited the machine. It was discussed with the CDM at the time of the observation that the curtains were not being maintained as per facility policy that included cleaning and sanitizing after each meal and de-liming the machine and dish runs on a regular basis. It was also discussed that as dishes passed and exited through the machine, the soiled curtains and water come into contact with resident dishware, resulting in contamination. The surveyor requested that the curtains be cleaned and sanitized and the machine de-limed prior to continued use of the dish machine. (Photographic Evidence Obtained). (c) Observation of the exhaust hood, which is located over the machine food preparation equipment noted that the front of the hood was covered with a large wood plank that was approximately 15 feet long. Further observation of the wood noted peeling paint down the entire surface of the wood plank. It was discussed with the CDM at the time of the observation that peeling paint was falling onto the equipment and food being prepared under the hood, resulting in food contamination. The surveyor requested that wood surface be prepped and repainted prior to the next meal service. (Photographic Evidence Obtained). (d) Observation of 4 food preparation skillet food preparation pans that were in use were noted to have a heavy build-up of black carbon matter on the interior and exterior surfaces. The surveyor requested that the pans be discarded and replaced as soon as possible to prevent food contamination during food preparation. (Photographic Evidence Obtained). (e) Soiled food cleaning cloths were noted to be stored directly on food preparation surfaces, clean utility carts, and 3-compartment sinks. The surveyor discussed with the CDM that regulatory requirement was to store all cleaning cloths in a sanitizing solution when not in use. (Photographic Evidence Obtained). (f) Observation of the entrance into the dietary department noted that 2 full carts of dishes were being stored outside of the dietary department. Further observation noted that carts were not covered and that food trays were full of exposed garbage and trash. The surveyor discussed with the CDM that the regulatory requirement was to always cover all garbage and trash completely. 2) During a second kitchen/food service observation tour conducted on 09/17/24 at 7:15 AM and accompanied with the Corporate Food Service Director (CFSD), the following were noted: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105298	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FT Lauderdale Health & Rehabilitation Center	2000 East Commercial Blvd Fort Lauderdale, FL 33308

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 - Few	(a) Temperatures of foods located on the tray assembly line were taken by the CDM with the use of the facility's calibrated digital food thermometer. The results of the temperature testing noted that hot foods were not being held at the regulatory temperature of 135 degrees F or above, and cold foods were not being held at the regulatory temperature of 41 degrees F or below, as per the following: < Fried Eggs (8 servings) = 88 degrees F. The surveyor requested that the eggs be discarded. < Orange Juice (50 servings) = 72 degrees F. Further investigation noted that the juice dispenser (orange, apple, cranberry) was not working properly and was not chilling the juice to the regulatory temperature of 41 degrees F or below. (b) Observation of the dish machine noted that the wash temperature was recorded at 125 degrees F. It was discussed with the CDM that the machine wash temperature did not meet the regulatory requirement of 150-165 degrees F. The CDM investigated the matter and reported to the surveyor that dietary staff failed to turn on the machine's hot water booster. (c) Observation of the dish machine room noted that there was a heavily soiled ladder being stored in the clean section of the room. The surveyor requested that the ladder be removed. (Photographic Evidence Obtained). (d) Observation of the 3-compartment sink area noted that an air-conditioning vent was located over the clean section of the sink area. Further observation noted that exterior of the vent was covered in a black mold type matter. The surveyor discussed with the CDM that the mold could result in clean food preparation equipment becoming contaminated and requested that the vent be cleaned and sanitized before use of the 3-compartment sink. (Photographic Evidence Obtained). (e) Observation of the 3-door reach-in refrigerator located in the main food preparation area was noted to have 2 internal food storage racks that were rust laden and in need of replacement. (Photographic Evidence Obtained). (f) Observation of the Convection Oven located underneath the hood exhaust system was noted to have 4 legs that were rust laden. (Photographic Evidence Obtained).