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
	100604	A. BUILDING: ______ B. WING ______	C 05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POMPANO HEALTH AND REHABILITATION CENTER	51 W SAMPLE ROAD POMPANO BEACH, FL 33064

(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
N 000	INITIAL COMMENTS A licensure complaint survey, for complaint number 2025006641, was conducted at Pompano Health and Rehabilitation Center on . The facility had deficiencies at the time of the survey.	N 000		
N 066 SS=B	400.23(3)(b)4, FS Posting Staff Each nursing home facility must document compliance with staffing standards as required under this paragraph and post daily the names of licensed nurses and certified nursing assistants on duty for the benefit of facility residents and the public. Facilities must maintain the records documenting compliance with minimum staffing standards for a period of 5 years and must report staffing in accordance with 42 C.F.R. s. 483.70(q). This Statute or Rule is not met as evidenced by: Based on review of policy and procedure, observation and interview, the facility failed to ensure that it posted the current date for the Nurse Staffing Information for 2 of 5 posting areas observed. The findings included: Record review of the facility policy and procedure, titled, Staffing, provided by the Director of Nursing (DON) effective , documented in the "Policy Statement: The Administrator and DON [Director Of Nursing] are responsible to ensure sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable, physical, mental, and	N 066	1.) Staff posting was completed by the Staffing Coordinator, the Resident council President was notified, and no additional recommendations were provided on behalf of the resident council committee. 2.) A full house audit of staff posting areas was completed by the Nursing Home Administrator, and staff posting was updated. A resident council meeting was held; no residents were affected by this. 3.) Staffing coordinator educated by the Nursing Home Administrator/Designee on updating the staff posting throughout the facility each day, and the components of regulation F732/N066. 4.) Nursing Home Administrator/Designee	

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N 066	Continued From page 1	N 066		

well-being of each resident, as required by federal law and sufficient staff to meet applicable state law requirements (include minimum staffing ratios.) ...The facility Administrator and the DON should evaluate staffing on a daily basis ....Staffing: Daily Staffing Sheets ....3. Post sheets daily ...Other 1. Post the daily staffing hours..."

An observation on the entrance tour conducted on at 9:10 AM and again at 10:23 AM revealed there was an "Nursing Staff Posting Form" located at the front desk with the date of . Photographic Evidence Obtained.

On at 10:23 AM, it was observed there was a 'Nursing Staff Posting Form' posted in the main hallway near the conference room on the bulletin board, dated . Photographic Evidence Obtained.

Review of the bottom, lower portion of the posted "Nursing Staff Posting Form" indicated on the form itself that, 'this document is posted and updated daily'.

An interview was conducted with Staff A, Staffing Coordinator and Central Supply, on at 4:34 PM, regarding the 'Nurse Staff Postings', who stated that during the previous evening shift, she would post the following upcoming day Nurse Staff Posting Form 'behind' the current days Nurse Staff Posting Form. Staff A explained that the night nurse, who works the 11 PM to 7:30 AM shift, is the person responsible for changing out and removing the old Nurse Staff Posting, to expose the new Nurse Staff Posting, at midnight. Staff A acknowledged that the previous days Nurse Staff Posting Form was still posted, as of today, in both of the following areas: at the front desk receptionist area and in the main hallway

will conduct random audits to ensure staff posting is current, accurate, and visible to the residents twice weekly for four weeks, then weekly for four weeks then monthly for three months to ensure compliance. Findings of audits to be reported through the monthly Quality Assessment, Assurance and Compliance Committee meeting for three months for comments and recommendations.

Agency for Health Care Administration

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(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
N 066	Continued From page 2 bulletin board. On at 4:40 PM, the Administrator and the DON both acknowledged the Nurse Staffing Information Form must be posted daily with the current date. Class III	N 066		
N 201 SS=D	400.022(1)(l), FS Right to Adequate and Appropriate Health Care (l) The right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency. This Statute or Rule is not met as evidenced by: Based on review of policy and procedure, observation, interview and record review, the facility failed to ensure it obtained a current physician order for an ( ) and site; and failed to change the ( ) to the right upper . for 1 of 1 sampled resident observed, Resident #4. The findings included: Review of the facility policy and procedure, titled, Change for Access Devices, provided by the Director of Nursing (DON), reviewed 2011, documented in the "Policy Statement Purpose: To prevent local and systemic related to the .	N 201	1.) Resident #4's access change was completed per Physician's order, the Attending Physician was notified, care plan was added and an assessment was completed by RN Unit Manager, with no negative effects noted. 2.) Full house audit of residents with access site and skin checks were completed by the Director of Nursing/Designee and no other concerns identified. 3.) Licensed Nurses educated by Director of Nursing/Designee on providing adequate care and services in accordance	

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
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N 201	Continued From page 3 Policy: A sterile is maintained on all , and central access devices to protect the site, provide a microbial barrier, and to provide access device securement ...3. Central access device and , are changed every 7 days and immediately if the integrity of the is compromised, if moisture, drainage or is present, or for further assessment if is suspected ... and Central Access Device Change Procedure: ...4. Assess site for: , , , , Drainage ...18. Apply label on with date and nurse's initials ....20. Suggested charting: Site assessment, Measured external length of the , Prep used, Type of , securement (integrity of , other devices) and Resident response." Record review revealed Resident #4 was admitted to the facility on and re-admitted on with diagnoses that included , and , following affecting right dominant side, Type II, , , , , and Hypertensive with . The record documented a Brief Interview Mental Status ( ) score of 00, indicative of (severe ,). During an observation on at 10:37 AM, Resident #4 was observed sitting in the wheelchair in the hallway. It was noted the resident had an ( ) dated . Closer observation on at 2:08 PM, with the Director Of Nursing (DON) revealed the was still dated that was on the	N 201	with accepted professional standards to include following Physicians' orders, changing of access , and the components of regulation F694/N201. 4.) Director of Nursing/Designee will conduct random audits to ensure access are changed per physician's order twice weekly for four weeks, then weekly for four weeks then monthly for three months to ensure compliance. Findings of audits to be reported through the monthly Quality Assessment, Assurance and Compliance Committee meeting for three months for comments and recommendations.	

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N 201	Continued From page 4 resident's right Opti Flow port double lumen , (for , which was not required at that time) with the nurse's initials. Photographic Evidence Obtained. Review of the physician orders revealed that was the last and most recent order for: "Change , to right upper every seven (7) days as well as needed (PRN) for soiling and/or dislodgement every evening shift every Monday - order date 14:43 [2:43] PM D/C [discontinue] date at 15:00 PM." There was no current physician's order for the right upper , as of his re-admission date to the facility on . Record review of Resident #4's , care plan, initiated and revised , indicated "Focus: , ---the resident has Failure and is on , . Interventions: , Site---Observe for signs and symptoms of ,, for gross , at access consider calling 911 ...Goal: Will have minimal to no complications...". There was no specific care plan reviewed pertaining to Resident #4's right upper ( ) ,. Review of the , Medication Administration Record (MAR) revealed the resident's right , had been documented as having been changed on each of the following days: , , and , , with the last documented time that Resident #4's right , was changed was on: . . . ., per the nurses' initials on the MARs. Review of the ,	N 201		

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N 201	Continued From page 5 Treatment Administration Record (TAR) revealed no documentation pertaining to the resident's right , per the lack of nurses' initials. Review of the MARs revealed the resident's right was documented as having been changed on and , per the nurses' initials on the MAR. Review of the TARs revealed no documentation pertaining to the resident's right , per lack of nurses' initials. The date of was observed on the resident's right Opti Flow port double lumen during this current survey. There was no documentation reviewed in the nursing progress notes dated to that indicated Resident #4's right upper ( ) had been changed during these dates-of-service (DOS). There was no documentation to describe the resident's site status or the condition of the resident's skin underneath the outdated . An interview was conducted on at 2:05 PM with Staff B, Registered Nurse (RN) / South Unit Manager (UM) and the current direct care nurse for Resident #4, who stated she had not changed the right port . She acknowledged he right port was outdated and should have been changed. A side-by-side record review was conducted with the DON of all of the documentation notated above. The resident's right port site was not changed since and documented on the TAR as being done, until after surveyor	N 201		

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N 201	Continued From page 6 intervention. The DON acknowledged the findings on at 4:10 PM that Resident #4's right Opti Flow port double lumen should have had a current physician order and should have been changed and documented as per protocol. Class III	N 201		

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F 000	INITIAL COMMENTS A complaint survey for complaint number 2025006641, was conducted on at Pompano Health and Rehabilitation Center. The facility was not in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	F 000		
F 694 SS=D	/ Fluids CFR(s): 483.25(h) § 483.25(h) Fluids. fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on review of policy and procedure, observation, interview and record review, the facility failed to ensure it obtained a current physician order for an ( ) and site; and failed to change the ( ) to the right upper for 1 of 1 sampled resident observed, Resident #4. The findings included: Review of the facility policy and procedure, titled, Change for Access Devices, provided by the Director of Nursing (DON), reviewed 2011, documented in the "Policy Statement Purpose: To prevent local and systemic related to the . Policy: A sterile is maintained on all , , and central access devices to protect the site, provide a microbial barrier, and to provide access device securement ...3. Central access device and , ,	F 694	1.) Resident #4's access change was completed per Physician's order, the Attending Physician was notified, care plan was added and an assessment was completed by RN Unit Manager, with no negative effects noted. 2.) Full house audit of residents with access site and skin checks were completed by the Director of Nursing/Designee and no other concerns identified. 3.) Licensed Nurses educated by Director of Nursing/Designee on providing adequate care and services in accordance with accepted professional standards to include following Physicians' orders, changing of access , and the components of regulation F694/N201.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		/2025

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.

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F 694	Continued From page 1 are changed every 7 days and immediately if the integrity of the is compromised, if moisture, drainage or is present, or for further assessment if is suspected ... and Central Access Device Change Procedure: ...4. Assess site for: , , , Drainage ...18. Apply label on with date and nurse's initials ....20. Suggested charting: Site assessment, Measured external length of the , Prep used, Type of , securement (integrity of , other devices) and Resident response." Record review revealed Resident #4 was admitted to the facility on and re-admitted on with diagnoses that included , and , following affecting right dominant side, Type II, , , , and Hypertensive with . The record documented a Brief Interview Mental Status ( ) score of 00, indicative of (severe ,). During an observation on at 10:37 AM, Resident #4 was observed sitting in the wheelchair in the hallway. It was noted the resident had an ( ) dated . Closer observation on at 2:08 PM, with the Director Of Nursing (DON) revealed the was still dated that was on the resident's right Opti Flow port double lumen (for , which was not required at that time) with the nurse's initials. Photographic Evidence Obtained.	F 694	4.) Director of Nursing/Designee will conduct random audits to ensure access are changed per physician's order twice weekly for four weeks, then weekly for four weeks then monthly for three months to ensure compliance. Findings of audits to be reported through the monthly Quality Assessment, Assurance and Compliance Committee meeting for three months for comments and recommendations.	

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F 694	Continued From page 2	F 694		

Review of the physician orders revealed that was the last and most recent order for: "Change to right upper every seven (7) days as well as needed (PRN) for soiling and/or dislodgement every evening shift every Monday - order date 14:43 [2:43] PM D/C [discontinue] date at 15:00 PM."

There was no current physician's order for the right upper as of his re-admission date to the facility on .

Record review of Resident #4's care plan, initiated and revised , indicated "Focus: ---the resident has Failure and is on . Interventions: Site---Observe for signs and symptoms of , for gross at access consider calling 911 ...Goal: Will have minimal to no complications...".

There was no specific care plan reviewed pertaining to Resident #4's right upper ( ) .

Review of the , Medication Administration Record (MAR) revealed the resident's right had been documented as having been changed on each of the following days: , , and , , with the last documented time that Resident #4's right was changed was on: , per the nurses' initials on the MARs. Review of the Treatment Administration Record (TAR) revealed no documentation pertaining to the resident's right , per the lack of nurses'

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F 694	Continued From page 3 initials. Review of the MARs revealed the resident's right was documented as having been changed on and , per the nurses' initials on the MAR. Review of the TARs revealed no documentation pertaining to the resident's right , per lack of nurses' initials. The date of was observed on the resident's right Opti Flow port double lumen during this current survey. There was no documentation reviewed in the nursing progress notes dated to that indicated Resident #4's right upper ( ) had been changed during these dates-of-service (DOS). There was no documentation to describe the resident's site status or the condition of the resident's skin underneath the outdated . An interview was conducted on at 2:05 PM with Staff B, Registered Nurse (RN) / South Unit Manager (UM) and the current direct care nurse for Resident #4, who stated she had not changed the right port . She acknowledged he right port was outdated and should have been changed. A side-by-side record review was conducted with the DON of all of the documentation notated above. The resident's right port site was not changed since and documented on the TAR as being done, until after surveyor intervention.	F 694		

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F 694	Continued From page 4 The DON acknowledged the findings on at 4:10 PM that Resident #4's right Opti Flow port double lumen should have had a current physician order and should have been changed and documented as per protocol.	F 694		
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(i)(1)-(4) §483.35(i) Nurse Staffing Information. §483.35(i)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. ( ) Resident census. §483.35(i)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (i)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(i)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data	F 732		

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F 732	Continued From page 5	F 732		

available to the public for review at a cost not to exceed the community standard.

§483.35(i)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.
This REQUIREMENT is not met as evidenced by:
Based on review of policy and procedure, observation and interview, the facility failed to ensure that it posted the current date for the Nurse Staffing Information for 2 of 5 posting areas observed.

The findings included:

Record review of the facility policy and procedure, titled, Staffing, provided by the Director of Nursing (DON) effective , documented in the "Policy Statement: The Administrator and DON [Director Of Nursing] are responsible to ensure sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable, physical, mental, and well-being of each resident, as required by federal law and sufficient staff to meet applicable state law requirements (include minimum staffing ratios.) ...The facility Administrator and the DON should evaluate staffing on a daily basis ....Staffing: Daily Staffing Sheets ....3. Post sheets daily ...Other 1. Post the daily staffing hours..."

An observation on the entrance tour conducted on at 9:10 AM and again at 10:23 AM revealed there was an "Nursing Staff Posting Form" located at the front desk with the date of . Photographic Evidence Obtained.

Provider's Plan of Correction (F 732):

1.) Staff posting was completed by the Staffing Coordinator, the Resident council President was notified, and no additional recommendations were provided on behalf of the resident council committee.
2.) A full house audit of staff posting areas was completed by the Nursing Home Administrator, and staff posting was updated. A resident council meeting was held; no residents were affected by this.
3.) Staffing coordinator educated by the Nursing Home Administrator/Designee on updating the staff posting throughout the facility each day, and the components of regulation F732/N066.
4.) Nursing Home Administrator/Designee will conduct random audits to ensure staff posting is current, accurate, and visible to the residents twice weekly for four weeks, then weekly for four weeks then monthly for three months to ensure compliance. Findings of audits to be reported through the monthly Quality Assessment, Assurance and Compliance Committee meeting for three months for comments and recommendations.

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105572	A. BUILDING _______ B. WING _______	C 05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POMPANO HEALTH AND REHABILITATION CENTER	**51 W SAMPLE ROAD POMPANO BEACH, FL 33064**

(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) COMPLETION DATE
F 732	Continued From page 6 On at 10:23 AM, it was observed there was a 'Nursing Staff Posting Form' posted in the main hallway near the conference room on the bulletin board, dated . Photographic Evidence Obtained. Review of the bottom, lower portion of the posted "Nursing Staff Posting Form" indicated on the form itself that, 'this document is posted and updated daily'. An interview was conducted with Staff A, Staffing Coordinator and Central Supply, on at 4:34 PM, regarding the 'Nurse Staff Postings', who stated that during the previous evening shift, she would post the following upcoming day Nurse Staff Posting Form 'behind' the current days Nurse Staff Posting Form. Staff A explained that the night nurse, who works the 11 PM to 7:30 AM shift, is the person responsible for changing out and removing the old Nurse Staff Posting, to expose the new Nurse Staff Posting, at midnight. Staff A acknowledged that the previous days Nurse Staff Posting Form was still posted, as of today, in both of the following areas: at the front desk receptionist area and in the main hallway bulletin board. On at 4:40 PM, the Administrator and the DON both acknowledged the Nurse Staffing Information Form must be posted daily with the current date.	F 732		