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
	AL11922281	A. BUILDING: _____ B. WING _____	01/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTBROOKE MANOR	6701 DAIRY ROAD ZEPHYRHILLS, FL 33542

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CZ815 SS=C	408.809; 435.02(2); 435.06 FS Background Screening; Prohibited Offenses 408.809 Background screening; prohibited offenses.- (1) Level 2 background screening pursuant to chapter 435 must be conducted through the agency on each of the following persons, who are considered employees for the purposes of conducting screening under chapter 435: (a) The licensee, if an individual. (b) The administrator or a similarly titled person who is responsible for the day-to-day operation of the provider. (c) The financial officer or similarly titled individual who is responsible for the financial operation of the licensee or provider. (d) Any person who is a controlling interest. (e) Any person, as required by authorizing statutes, seeking employment with a licensee or provider who is expected to, or whose responsibilities may require him or her to, provide personal care or services directly to clients or have access to client funds, personal property, or living areas; and any person, as required by authorizing statutes, [illegible] with a licensee or provider whose responsibilities require him or her to provide personal care or personal services directly to clients, or [illegible] with a licensee or provider to work 20 hours a week or more who will have access to client funds, personal property, or living areas. Evidence of contractor screening may be retained by the contractor's employer or the licensee. (3) All [illegible] must be provided in electronic format. Screening results shall be reviewed by the agency with respect to the offenses specified in s. 435.04 and this section, and the qualifying or disqualifying status of the person named in the request shall be maintained in a database. The	CZ815		

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

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CZ815	Continued From page 1	CZ815		

qualifying or disqualifying status of the person named in the request shall be posted on a secure website for retrieval by the licensee or designated agent on the licensee's behalf.
(4) In addition to the offenses listed in s. 435.04, all persons required to undergo background screening pursuant to this part or authorizing statutes must not have an awaiting final disposition for, must not have been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, and must not have been adjudicated delinquent and the record not have been sealed or expunged for any of the following offenses or any similar offense of another jurisdiction:
(a) Any authorizing statutes, if the offense was a felony.
(b) This chapter, if the offense was a felony.
(c) Section 409.920, relating to Medicaid provider fraud.
(d) Section 409.9201, relating to Medicaid fraud.
(e) Section 741.28, relating to domestic violence.
(f) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.
(g) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems.
(h) Section 817.234, relating to false and fraudulent insurance claims.
(i) Section 817.481, relating to obtaining goods by using a false or expired credit card or other credit device, if the offense was a felony.
(j) Section 817.50, relating to fraudulently obtaining goods or services from a health care provider.
(k) Section 817.505, relating to patient brokering.
(l) Section 817.568, relating to criminal use of personal identification information.

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CZ815	Continued From page 2 (m) Section 817.60, relating to obtaining a credit card through fraudulent means. (n) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony. (o) Section 831.01, relating to forgery. (p) Section 831.02, relating to uttering forged instruments. (q) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes. (r) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes. (s) Section 831.30, relating to fraud in obtaining medicinal drugs. (t) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony. (u) Section 895.03, relating to racketeering and collection of unlawful debts. (v) Section 896.101, relating to the Florida Money Laundering Act. If, upon rescreening, a person who is currently employed or with a licensee as of , and was screened and qualified under ss. 435.03 and 435.04, has a disqualifying offense that was not a disqualifying offense at the time of the last screening, but is a current disqualifying offense and was committed before the last screening, he or she may apply for an exemption from the appropriate licensing agency and, if agreed to by the employer, may continue to perform his or her duties until the licensing agency renders a decision on the application for exemption if the person is eligible to apply for an exemption and the exemption request is received by the agency no later than 30 days after receipt of the rescreening results by the person. (5) A person who serves as a controlling interest	CZ815		

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CZ815	Continued From page 3 of, is employed by, or contracts with a licensee on , , , who has been screened and qualified according to standards specified in s. 435.03 or s. 435.04 must be rescreened by , , , in compliance with the following schedule. If, upon rescreening, such person has a disqualifying offense that was not a disqualifying offense at the time of the last screening, but is a current disqualifying offense and was committed before the last screening, he or she may apply for an exemption from the appropriate licensing agency and, if agreed to by the employer, may continue to perform his or her duties until the licensing agency renders a decision on the application for exemption if the person is eligible to apply for an exemption and the exemption request is received by the agency within 30 days after receipt of the rescreening results by the person. The rescreening schedule shall be: (a) Individuals for whom the last screening was conducted on or before , , must be rescreened by , , . (b) Individuals for whom the last screening conducted was between , , , and , , must be rescreened by , , . (c) Individuals for whom the last screening conducted was between , , , through , , must be rescreened by , , . (6) The costs associated with obtaining the required screening must be borne by the licensee or the person subject to screening. Licensees may reimburse persons for these costs. The Department of Law Enforcement shall charge the agency for screening pursuant to s. 943.053(3). The agency shall establish a schedule of fees to cover the costs of screening.	CZ815		

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CZ815	Continued From page 4 (7)(a) As provided in chapter 435, the agency may grant an exemption from disqualification to a person who is subject to this section and who: 1. Does not have an active professional license or certification from the Department of Health; or 2. Has an active professional license or certification from the Department of Health but is not providing a service within the scope of that license or certification. (b) As provided in chapter 435, the appropriate regulatory board within the Department of Health, or the department itself if there is no board, may grant an exemption from disqualification to a person who is subject to this section and who has received a professional license or certification from the Department of Health or a regulatory board within that department and that person is providing a service within the scope of his or her licensed or certified practice. (8) The agency and the Department of Health may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement this section, chapter 435, and authorizing statutes requiring background screening and to implement and adopt criteria relating to retaining [illegible] pursuant to s. 943.05(2). (9) There is no reemployment assistance or other monetary liability on the part of, and no cause of action for damages arising against, an employer that, upon notice of a disqualifying offense listed under chapter 435 or this section, terminates the person against whom the report was issued, whether or not that person has filed for an exemption with the Department of Health or the agency. 435.06 Exclusion from employment.- (1) If an employer or agency has reasonable cause to believe that grounds exist for the denial	CZ815		

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CZ815	Continued From page 5 or termination of employment of any employee as a result of background screening, it shall notify the employee in writing, stating the specific record that indicates noncompliance with the standards in this chapter. It is the responsibility of the affected employee to contest his or her disqualification or to request exemption from disqualification. The only basis for contesting the disqualification is proof of mistaken identity. (2)(a) An employer may not hire, select, or otherwise allow an employee to have contact with any person that would place the employee in a role that requires background screening until the screening process is completed and demonstrates the absence of any grounds for the denial or termination of employment. If the screening process shows any grounds for the denial or termination of employment, the employer may not hire, select, or otherwise allow the employee to have contact with any person that would place the employee in a role that requires background screening unless the employee is granted an exemption for the disqualification by the agency as provided under s. 435.07. (b) If an employer becomes aware that an employee has been for a disqualifying offense, the employer must remove the employee from contact with any person that places the employee in a role that requires background screening until the is resolved in a way that the employer determines that the employee is still eligible for employment under this chapter. (c) The employer must terminate the employment of any of its personnel found to be in noncompliance with the minimum standards of this chapter or place the employee in a position for which background screening is not required	CZ815		

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CZ815	Continued From page 6 unless the employee is granted an exemption from disqualification pursuant to s. 435.07. (d) An employer may hire an employee to a position that requires background screening before the employee completes the screening process for training and orientation purposes. However, the employee may not have direct contact with persons until the screening process is completed and the employee demonstrates that he or she exhibits no behaviors that warrant the denial or termination of employment. (3) Any employee who refuses to cooperate in such screening or refuses to timely submit the information necessary to complete the screening, including , , if required, must be disqualified for employment in such position or, if employed, must be dismissed. (4) There is no reemployment assistance or other monetary liability on the part of, and no cause of action for damages against, an employer that, upon notice of a conviction or for a disqualifying offense listed under this chapter, terminates the person against whom the report was issued or who was , regardless of whether or not that person has filed for an exemption pursuant to this chapter. 435.02 Definitions.-For the purposes of this chapter, the term: (2) "Employee" means any person required by law to be screened pursuant to this chapter, including, but not limited to, persons who are contractors, licensees, or volunteers. This Statute or Rule is not met as evidenced by: Based on record reviews and interview the facility failed to ensure that a Level Two Background Screening was completed for three (Staff A,	CZ815		

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CZ815	Continued From page 7 Staff B and Staff E) out of six sampled employees who provided direct care to residents. Findings included: A review of Staff A employee personnel file on . . . . . revealed that she was hired on . . . . . A further review of Staff A personnel file revealed no evidence of a completed Level Two Background Screening. A review of Staff B employee personnel file on . . . . . revealed that she was hired on . . . . . A further review of Staff B personnel file revealed an expired Level Two Background Screening from . . . . . Staff B personnel file did not reveal any evidence of a current Level Two Background Screening. A review of Staff E employee personnel file on . . . . . revealed that she was hired on . . . . . A further review of Staff E personnel file revealed no evidence of a completed Level Two Background Screening. The above findings were shared during an interview with the facility's Executive Director (ED) on /20202 at 2:43 PM. During this interview the ED confirmed the missing documentation and stated, " I couldn't find their documentation but I will be sure to get all of them up to date." Unclassified	CZ815		
CZ816 SS=C	408.809(2a-c) 435.05(2) 59A-35.090(2d-3c Background Screening-Compliance Attestation 408.809 Background screening; prohibited	CZ816		

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CZ816	Continued From page 8 offenses.- (2) Every 5 years following his or her licensure, employment, or entry into a contract in a capacity that under subsection (1) would require level 2 background screening under chapter 435, each such person must submit to level 2 background rescreening as a condition of retaining such license or continuing in such employment or contractual status. For any such rescreening, the agency shall request the Department of Law Enforcement to forward the person's ... to the Federal Bureau of Investigation for a national criminal history record check unless the person's ... are enrolled in the Federal Bureau of Investigation's national retained print notification program. If the ... of such a person are not retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h), the person must submit ... electronically to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the ... to the Federal Bureau of Investigation for a national criminal history record check. The ... shall be retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h) and enrolled in the national retained print notification program when the Department of Law Enforcement begins participation in the program. The cost of the state and national criminal history records checks required by level 2 screening may be borne by the licensee or the person ... Until a specified agency is fully implemented in the clearinghouse created under s. 435.12, the agency may accept as satisfying the requirements of this section proof of compliance with level 2 screening standards submitted within the previous 5 years to meet any provider or	CZ816		

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CZ816	Continued From page 9 professional licensure requirements of the agency, the Department of Health, the Department of Elderly Affairs, the Agency for Persons with , the Department of Children and Families, or the Department of Financial Services for an applicant for a certificate of authority or provisional certificate of authority to operate a continuing care retirement community under chapter 651, provided that: (a) The screening standards and disqualifying offenses for the prior screening are equivalent to those specified in s. 435.04 and this section; (b) The person subject to screening has not had a break in service from a position that requires level 2 screening for more than 90 days; and (c) Such proof is accompanied, under penalty of perjury, by an attestation of compliance with chapter 435 and this section using forms provided by the agency. 435.05 Requirements for covered employees and employers.-Except as otherwise provided by law, the following requirements apply to covered employees and employers: (2) Every employee must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if for any of the disqualifying offenses while employed by the employer. 59A-35.090 Background Screening. (2) Processing Screening Requests, Required Documents and Fees. (d) An Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008, , herein incorporated by reference, available at http://www.flrules.org/Gateway/reference.asp?No	CZ816		

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CZ816	Continued From page 10 =Ref-09106, and available from the Agency for Health Care Administration at: http://ahca.myflorida.com/MCHQ/Central_Services/Background_Screening/Regulations_Forms.shtml. This form must be completed by the individual and retained by the provider upon hire to attest that they meet the requirements for qualifying for employment, they have not been unemployed for more than 90 days from a position that requires Level 2 screening, and they agree to inform the employer immediately if for any disqualifying offense. (e) An administrator or chief financial officer must be screened and qualified prior to to the position. (3) Results of Screening and Notification. (a) Final results of background screening requests will be provided through the Agency's secure website that may be accessed by all health care providers applying for or actively licensed through the Agency that are registered with the Care Provider Background Screening Clearinghouse. The secure website is located at: apps.ahca.myflorida.com/SingleSignOnPortal. (b) If a Level 2 criminal history is incomplete, a certified letter will be sent to the individual being screened requesting the report and court disposition information. If the letter is returned unclaimed, a copy of the letter will be sent by regular mail. Pursuant to section 435.05(1)(d), F.S., the missing information must be filed with the Agency within 30 days of the Agency's request or the individual is subject to disqualification in accordance with section 435.06(3), F.S. (c) The eligibility results of employee screening and the signed Attestation referenced in subsection 59A-35.090(2), F.A.C., must be in the employee's personnel file, maintained by the	CZ816		

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CZ816	Continued From page 11 provider. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that an Attestation of Compliance was signed and included in employee records for three (Staff B, C, and E) of six sampled employee records. Findings Included: An employee record review for Staff B was conducted on and revealed Staff B was hired on . . . . . A further review of Staff B employee record did not reveal any evidence of a signed Attestation of Compliance. An employee record review for Staff C was conducted on and revealed Staff C was hired on . . . . . A further review of Staff C employee record did not reveal any evidence of a signed Attestation of Compliance. An employee record review for Staff E was conducted on and revealed Staff E was hired on . . . . . A further review of Staff E employee record did not reveal any evidence of a signed Attestation of Compliance. The above findings were shared during an interview with the facility's Executive Director (ED) on . . . . /20202 at 2:43 PM. During this interview the ED confirmed the missing documentation and stated," I couldn't find their documentation but I will be sure to get all of them up to date." Unclassified	CZ816		

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A 081 SS=D	59A-36.011( ) FAC Training - Staff In-Service (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service	A 081		

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A 081	Continued From page 1 training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident . . . . ., neglect, and , . The facility must use its . . . . prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the	A 081		

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A 081	Continued From page 2 implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on record reviews and interview the facility failed to provide 2-hours of Pre-service Orientation covering resident rights, the Facility's license type, and the services offered by the Facility prior to interacting with residents for two (Staff D and Staff E) out of six sampled employees. Findings Included: A record review for Staff D was conducted on and revealed that she was hired on . . . . . The record review further revealed that Staff D personell file did not include any evidence of recieving 2-hours of Preservice Orientation Training. A record review for Staff E was conducted on . . . . . and revealed that she was hired on . . . . . The record review further revealed that Staff E personell file did not include any evidence of recieving 2-hours of Preservice Orientation Training. The above findings were shared during an inteview with the facility's Executive Director (ED) on . . . /20202 at 2:43 PM. During this interview the ED confirmed the missing doucmentation and stated," I couldnt find their documentation but I will be sure to get all of them up to date." Class III	A 081		
A 093 SS=D	59A-36.012(2) FAC Food Service - Dietary Standards	A 093		

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A 093	Continued From page 3 (2) DIETARY STANDARDS. (a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2010, which are incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04003, and the current summary of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2010, which are incorporated by reference and available for review at: http://iom.edu/Activities/Nutrition/SummaryDRIs/~/media/Files/Activity%20Files/Nutrition/DRIs/New%20Material/5DRI%20Values%20SummaryTables%2014.pdf. Therapeutic diets must meet these nutritional standards to the extent possible. (b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the residents, and must be prepared through the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes. (c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of the reviewer, registration or license number, and	A 093		

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A 093	Continued From page 4 date reviewed. Portion sizes must be indicated on the menus or on a separate sheet. 1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. 2. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents. (d) Menus must be dated and planned at least 1 week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months. (e) Therapeutic diets must be prepared and served as ordered by the health care provider. 1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining, or family style dining are not required to document what is eaten unless a health care provider's order indicates that such monitoring is necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility. 2. The facility must document a resident's refusal to comply with a therapeutic diet and provide notification to the resident's health care provider of such refusal. (f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals must be evenly	A 093		

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A 093	Continued From page 5 distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of . . . . . , the time between meals. (g) Food must be served attractively at safe and palatable temperatures. All residents must be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, must be on . . . (h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has with residents to serve, must be on at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must also be stored, or the facility must have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to maintain a 3-day supply of food to be used in the event of an emergency. Findings included: A tour of the facility's emergency stoarge area was completed with the Dietary Manager on at 9:05 AM. The tour revealed no evidence of the facility's having a 3-day emergency food supply. An interview was conducted with the Dietary	A 093		

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A 093	Continued From page 6 Manager on . . . . . at 9:05 AM. During this interview the Dietary Manager stated," I know that I don't have the 3 day supply of foods. We had a bunch of expired items that I had to get rid off and now in the process of reodering. Usually we just rotate items when they are about to expire. I don't know what happened . I know that I don't have what supposed to have but I rather have no food on the shelf than expired food." Class III	A 093		
A 152 SS=D	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable . . to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, ... or other furniture designed for	A 152		

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A 152	Continued From page 7 storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . . . . . . This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the Facility failed to provide a safe living environment by failing to safely store and maintain portable . . . . tanks. Findings Included: A tour of the Facility, conducted on . . . . . at 04:40am, revealed on medium portable . . . tank in the medication room that was not in secured rack or holder (See Photographic Evidence1). At 05:53am, a medium sized portable . . . tank was observed in the sunroom down the B-wing, behind a recliner, that was not in a secured rack or holder (See Photographic Evidence4). A review of the Facility's . . . . storage policy and procedures, conducted on . . . . , revealed that the Facility's . . . . storage policy and procedures stated that " . . . compressed gas bottles will be stored in metal compressed gas bottle racks ...or in the portable rolling device"	A 152		

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A 152	Continued From page 8 and "bottles, full or empty, are to be stored upright in approved/supplied metal bottle racks in an area safe from traffic and in an area safe from getting knocked over". A review of The National Fire and Protection Association (NFPA) and Occupational Safety and Health Administration standard for safe cylinder storage, conducted on , revealed that both agencies recommended that that "all freestanding cylinders must be stored in a rack, a cart, or another enclosure to protect them. Unsecured cylinders could , breaking the valve and possibly resulting in a rapid release of the gas, propelling the cylinder and turning it into a dangerous projectile." During an interview with the Administrator and the Director of Nursing, conducted on at 01:30pm, both were unable to state safe storage of portable tanks. Class III	A 152		
A 160 SS=D	59A-36.015(1) FAC Records - Facility The facility must maintain required records in a manner that makes such records readily available at the licensee's physical address for review by a legally authorized entity. If records are maintained in an electronic format, facility staff must be readily available to access the data and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce documents, records, or other such data, either in electronic or paper format, upon request. (1) FACILITY RECORDS. Facility records must include:	A 160		

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A 160	Continued From page 9 (a) The facility's license displayed in a conspicuous and public place within the facility. (b) An up-to-date admission and discharge log listing the names of all residents and each resident's: 1. Date of admission, the facility or place from which the resident was admitted, and if applicable, a notation indicating that the resident was admitted with a [illegible]; and, 2. Date of discharge, reason for discharge, and identification of the facility or home address to which the resident was discharged. Readmission of a resident to the facility after discharge requires a new entry in the log. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but intending to return pursuant to rule 59A-36.018, F.A.C. If the resident dies while in the care of the facility, the log must indicate the date of [illegible]. (c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b). (d) The facility's emergency management plan, with documentation of review and approval by the county emergency management agency, as described in rule 59A-36.019, F.A.C., that must be readily available by facility staff. (e) The facility's liability insurance policy required in rule 59A-36.013, F.A.C. (f) For facilities that have a surety bond, a copy of the surety bond currently in effect as required by rule 59A-36.013, F.A.C. (g) The admission package presented to new or prospective residents (less the resident's contract) described in rule 59A-36.006, F.A.C. (h) If the facility advertises that it provides special care for persons with [illegible]'s [illegible] or related [illegible], a copy of all such facility	A 160		

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A 160	Continued From page 10 advertisements as required by section 429.177, F.S. (i) A grievance procedure for receiving and responding to resident complaints and recommendations as described in rule 59A-36.007, F.A.C. (j) All food service records required in rule 59A-36.012, F.A.C., including menus planned and served and county health department inspection reports. Facilities that contract for food services, must include a copy of the contract for food services and the food service contractor's license or certificate to operate. (k) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to section 429.41, F.S., and rule chapter 69A-40, F.A.C., issued within the last 2 years. (l) All sanitation inspection reports issued by the county health department pursuant to section 381.031, F.S., and chapter 64E-12, F.A.C., issued within the last 2 years. (m) Pursuant to section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the last 5 years. (n) The facility's resident elopement response policies and procedures. (o) The facility's documented resident elopement response drills. (p) For facilities licensed as limited mental health, extended congregate care, or limited nursing services, records required as stated in rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview, the Facility failed to maintain an up-to-date admission and discharge log with all required admission and	A 160		

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A 160	Continued From page 11 discharge data. Findings Included: A review of the admission and discharge log and comparison with the resident roster, conducted on . . . . . , revealed that the admission and discharge did not include each resident's discharge data. Resident #32, #33, #34 were listed on the admission and discharge log as in-house residents but the residents were not on the resident roster that was provided. The admission and discharge log indicated that there were eighty-seven residents admitted to the Facility, but the resident roster indicated that there were one hundred and one residents admitted to the Facility. During an interview with the Administrator, conducted on at 07:30pm, the Administrator stated that Resident #32 was . . . . from the Facility; Resident #33 was . . . . . ; and, Resident #34 had moved from the Facility. The Administrator confirmed that there were ninety-four residents in-house and seven residents in the Hospital or Rehabilitation. Class III	A 160		
A 162 SS=D	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,	A 162		

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A 162	Continued From page 12 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 health care provider and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 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 paragraph 59A-36.007(1)(e), 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. (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	A 162		

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A 162	Continued From page 13	A 162		

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, , , 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

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A 162	Continued From page 14 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 the following at the discretion of the facility: 1. A log listing the names of residents participating in this arrangement, 2. The resident demographic data required in this paragraph, 3. The health assessment described in rule 59A-36.006, F.A.C., 4. The resident's contract described in rule 59A-36.018, F.A.C.; and, 5. A health care provider's order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility. (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, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview, the Facility failed to maintain resident records for Hospice residents with the required Interdisciplinary Care Plan ( ), a Hospice Admission or Consent Form, an authorization by a health care provider for Hospice services, and obtain a new -to- health assessments documented on the Agency for Health Care Administration Form	A 162		

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A 162	Continued From page 15 1823 (1823), with all required data, when the residents had significant declines in condition, necessitating their admission to Hospice services for two Residents (#3 and #16) of two sampled residents. Findings Included: A record review for Resident #3, conducted on , revealed that Resident #3 was admitted to Hospice services on an unknown date. There was no consent signed by Resident #3 or the Resident's Responsible Party for Hospice services. There was no authorization or order from Resident #3's Health Care Provider for Hospice services. Resident #3's most recent 1823 dated did not include the resident's required nursing services of Hospice on page one or the Examiner's telephone number or address. Resident #3's record did not include an interdisciplinary care plan specifying the care and services that Hospice would provide and those that the Facility would provide. Resident #3 was admitted into the Facility on . A record review for Resident #16, conducted on , revealed that Resident #16 was admitted to Hospice services on according to one document found. However, there was no consent signed by Resident #16 or the Resident's Responsible Party for Hospice services. There was no authorization or order from Resident #16's Health Care Provider for Hospice services. Resident #16's most recent 1823 dated did not include the resident's required nursing services of Hospice on page one or the Examiner's telephone number or address. Resident #16's record did not include an interdisciplinary care plan specifying the care and services that Hospice would provide and	A 162		

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A 162	Continued From page 16 those that the Facility would provide. Resident #16 was admitted into the Facility on . During an interview with the Administrator and the Director of Nursing, conducted on at 01:30pm, the Administrator and Director of Nursing agreed that the Facility did not obtain a new -to- health assessment for Resident #3 and #16 when they were admitted to Hospice services; did not obtain consents by the resident for Hospice services or authorizations from the Health Care Providers; and, did not obtain interdisciplinary care plans for Resident #3 and #16. Class III	A 162		
A 000	Initial Comments A Biennial Re-licensure with Extended Congregate Care (ECC) and a Complaint Investigation (Complaint Numbers 2019016845 and 2019018012) were conducted at Westbrook Manor on . Deficiencies were identified at the time of survey.	A 000		
A 052 SS=D	429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, including an syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer, from where it is stored, and bringing it to the resident. (b) In the presence of the resident, reading the	A 052		

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A 052	Continued From page 17	A 052		

label, opening the container, removing a prescribed amount of medication from the container, and closing the container.
(c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his or her .
(d) Applying , medications.
(e) Returning the medication container to proper storage.
(f) Keeping a record of when a resident receives assistance with self-administration under this section.
(g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the .
(h) Using a to perform level checks.
(i) Assisting with putting on and taking off stockings.
(j) Assisting with applying and removing an but not with titrating the prescribed settings.
(k) Assisting with the use of a continuous positive airway pressure device but not with titrating the prescribed setting of the device.
(l) Assisting with measuring vital signs.
(m) Assisting with bags.

(4) Assistance with self-administration does not include:
(a) Mixing, , , converting, or medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed.
(b) The preparation of syringes for injection or the

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A 052	Continued From page 18 administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a , of the body. (d) Administration of , preparations. (e) Irrigations or debriding agents used in the treatment of a skin condition. (f) , , or preparations. (g) Medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and at the request of a competent resident. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be , or older, trained to assist with self administered medication pursuant to the training requirements of rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in section 429.256, F.S. and this rule. (b) In addition to the specifications of section	A 052		

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A 052	Continued From page 19 429.256(3), F.S., assistance with self-administration of medication includes, in the presence of the resident, reading the medication label aloud and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging.	A 052		

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A 052	Continued From page 20 (f) Assistance with self-administration of medication does not include the activities detailed in section 429.256(4), F.S. 1. As used in section 429.256(4)(g), F.S., the term "competent resident" means that the resident is cognizant of when a medication is required and understands the purpose for taking the medication. 2. As used in section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (g) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation and interview, the Facility failed to ensure proper assistance with self-administration of medications according to the required steps in 429.256 Florida Statutes by not reading medication (med) labels to resident; not comparing med labels to Medication Observation Records (MORs); signing meds out as given prior to giving; and, not popping pills out of med packs in front of six residents (#6, #7, #8, #22, #27, and #31) of six sampled residents that required assistance with self-administration of medication. Findings Included: During an observation of the medication pass with Staff C, an unlicensed Medication Technician, for Residents #22, #27, and #31 conducted on at 05:03am. Staff C signed out Resident #31's meds , 150 micrograms and , 20mg prior to	A 052		

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A 052	Continued From page 21 giving the meds to the resident, closed the MORs, and pulled the meds from the med cart. Staff C did not compare the med label to the MORs. Staff C popped out the pills from the med packs at the med cart into a soufflé cup and carried the cup to the resident who was in her room. Staff did not take the med packs to Resident #31's room and was unable to read the med labels to the resident. At 05:05am, Staff C signed out Resident #27's med 70 milligrams (mg) prior to giving the med to the resident, closed the MORs, and pulled the med from the med cart. Staff C did not compare the med label to the MORs. Staff C popped out the pill from the med pack at the med cart into a souffle cup and carried the cup to the resident who was in her room. Staff did not take the med pack to Resident #27's room and was unable to read the med labels to the resident. At 05:09am, Staff C signed out Resident #22's med 20mg prior to giving the med to the resident, closed the MORs, and pulled the med from the med cart. Staff C did not compare the med label to the MORs. Staff C popped out the pill from the med pack at the med cart into a souffle cup and carried the cup to the resident who was in her room. Staff did not take the med pack to Resident #22's room and was unable to read the med labels to the resident. During an observation with Staff H, an unlicensed Medication Technician, for Residents #6, #7, and #8, conducted on at 10:24am, Staff H handed Resident #6 her meds and stated that "these are your eight o' clock meds". Staff H did not read Resident #6 the med labels. Staff H continued with the 08:00am med pass and gave Resident #8 her 08:00am meds at 10:33am. At 10:36am, Staff H prepped Resident #7's meds at the med cart placing each pill in applesauce in a	A 052		

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A 052	Continued From page 22 plastic med cup. The MORs were closed and Staff H placed the med packs in the med cart. Staff H carried the meds to Resident #7's room. Staff H did not bring the resident's med packs into the room and was unable to read the med labels to Resident #7. During an interview with Staff H, conducted on at 10:24am, Staff H stated that the 08:00am med pass was late because "the nurse had my MORs and I am running late". During an interview with the Administrator and the Director of Nursing, conducted on at 01:30pm, the Administrator and the Director of Nursing agreed that the standard for med pass is one hour before and one hour after a med is scheduled and that unlicensed Medication Technicians should follow their training. The Administrator and the Director of Nursing agreed that reading med labels, comparing med labels to MORs, and popping out pills in front of residents were a part of their Medication Technician training. Class III	A 052		
A 054 SS=D	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.	A 054		

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A 054	Continued From page 23 (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 [illegible] 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. (c) For medications that serve as chemical [illegible], 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 record review and interview, the Facility failed to maintain a daily Medication Observation Records (MORs) for each resident with all required data and failed to update MORs immediately each time the medications (meds) were offered for four Residents (#5, #6, #9, and #13) of four sampled residents that required assistance with self-administration of medications. Findings Included: A review of [illegible] MORs for Residents #5, conducted on [illegible], revealed that Resident #5's MORs did not include the resident's, Health Care Provider's name or	A 054		

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A 054	Continued From page 24 telephone number as required. Resident #5 had meds not documented as given to the resident. Resident #5's prescribed med 6 milligrams (mg) was not documented as given to the resident on at 05:00pm. Resident #5's prescribed med Refresh Tear , Solution was not documented as given to the resident from through at 08:00pm. Resident #5' prescribed med 20mg was not documented as given to the resident on at 08:00pm. Resident #5's prescribed med , 40mg was not documented as given to the resident on at 08:00pm. Resident #5's prescribed med 1 Gram was not documented as given to the resident on at 11:00am. A review of , MORs for Residents #6, conducted on , revealed that Resident #6's MORs did not include the resident's, Health Care Provider's name or telephone number as required. Resident #6 had meds not documented as given to the resident. Resident #6's prescribed med , 0.5mg was not documented as given to the resident on at 08:00pm. Resident #6's prescribed med 5mg was not documented as given to the resident on at 08:00pm. Resident #6's prescribed med 30mg was not documented as given to the resident on at 05:00pm. Resident #5's prescribed med 1 Gram was not documented as given to the resident on at 11:00am. A review of , MORs for Residents #9, conducted on , revealed that Resident #9's MORs did not include the resident's, Health Care Provider's name or telephone number as required. Resident #9 had a	A 054		

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A 054	Continued From page 25 med not documented as given to the resident. Resident #9's prescribed med , 12 microgram patch was not documented as given to the resident on at 08:00am. A review of , MORs for Residents #13, conducted on , revealed that Resident #13's MORs did not include the resident's, Health Care Provider's name or telephone number as required. Resident #13 had a med not documented as given to the resident. Resident #13's prescribed med , 325mg was not documented as given to the resident on at 10:00pm. During an interview with the Administrator and the Director of Nursing, conducted on , the Administrator and the Director of Nursing, after reviewing the MORs, agreed that there was missing documentation that Residents #5, #6, #9, and #13 had received their meds as ordered. Class III	A 054		
A 055 SS=D	59A-36.008(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents.	A 055		

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A 055	Continued From page 26 (b) Both prescription and over-the-counter medications for residents must be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed; 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or 6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in rule 59A-36.006, F.A.C. (c) Centrally stored medications must be: 1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times; 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and,	A 055		

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A 055	Continued From page 27 4. Kept separately from the medications of other residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider. (e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the Facility failed keep centrally stored medications locked and secured, at all times. Furthermore, the Facility failed to store	A 055		

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	AL11922281	A. BUILDING: _____ B. WING _____	01/22/2020

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A 055	Continued From page 28 discontinued medication separately from medication that were in-use for two Residents (#22 and #31) of two sampled residents. Findings Included: During a tour of the Facility, conducted on at 04:52am, there was a room in the main lobby/sitting area with the name "Pharmacy" over the doorway. The door was wide open and there was no staff present inside or in the area outside of the room. There was a paper bag with medications on the desk and a tote on the floor overflowing with medications (Photographic Evidence Obtained). There were residents in the surrounding area but no staff. During another observation at 10:33am, Staff H entered Resident #8's room leaving the medication cart unlocked/unsecured and out of sight of the staff. During a medication reconciliation for Resident #22 and #31 with Staff I, conducted on , revealed that the Facility did not separate medications that were discontinued from the medication that were in use. Resident #22's , 25mg was discontinued on and the medication remained in the medication cart with the current , 50mg medication. Resident #31 had a bottle of , 81mg with the resident's other medications and the medication was not listed on the resident's Medication Observation Record as a current medication. During an interview with the Administrator and Director of Nursing, conducted on at 01:30pm, both agreed that medications should be locked and secured at all times. The Administrator stated that Resident #22's , 25mg should not be in the medication	A 055		

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A 055	Continued From page 29 cart. The Administrator state that Resident #31 did not have an active order for , . Class III	A 055		
A 056 SS=D	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with chapters 465 and 499, F.S., and rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the	A 056		

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A 056	Continued From page 30 medication record, or a revised label must be obtained from the pharmacist. (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record. (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable. (f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner. (g) Pursuant to section 465.0276(5), F.S., and rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following:	A 056		

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A 056	Continued From page 31 1. Practitioner's name, 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and, 6. Expiration date. (h) Pursuant to section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the Facility failed obtain labels for a change in the directions of use for two Residents (#6 and #22) and failed to follow a Health Care Provider's order for one Resident (#27) of three sampled resident that required assistance with self-administration of medication. Findings Included: During an observation of the medication pass with Staff C, an unlicensed Medication Technician for Resident #27, conducted on . . . . . at 05:05am, Staff C took the resident 70mg into the resident's room and the resident was in bed. The resident raised up a little to take the medication and laid . . . down. Staff C left the room and did not instruct Resident #27 to remain upright for thirty minutes after taking the medication. A review of Resident #27's order, conducted on . . . . . , revealed that the order was to take 70mg before breakfast once per week and to remain upright for thirty minutes after taking.	A 056		

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A 056	Continued From page 32 A medication reconciliation for Resident #6 and #22 with Staff H, conducted on , revealed that the Facility had medication labels that did not match the resident's Medication Observation Records. Resident #6 had a medication pack of 100 milligrams (mg) take one tablet every day. Resident #6's Medication Observation Record stated 50mg take two tablets every day. Resident #22 had a medication pack of 50mg take one tablet every four hours as needed for . Resident #22's Medication Observation Record stated 50mg take one tablet every twelve hours as needed for . During an interview with the Administrator and Director of Nursing, conducted on at 01:30pm, both agreed that Staff C should have followed Resident #27's Health Care Provider's order to and reminded the resident to remain upright after taking the medication. The Administrator and the Director of Nursing agreed that all medication labels should match the Medication Observation Records to prevent the additional risk of a medication error. Class III	A 056		
A 078 SS=D	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before	A 078		

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A 078	Continued From page 33 submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of . . . . . testing materials satisfies the annual . . . examination requirement. An individual with a positive . . . . . test must submit a health care provider's statement that the individual does not constitute a risk of . 2. If any staff member has, or is suspected of having, a communicable , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable . . . . . . (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility to provide services to residents must ensure that	A 078		

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A 078	Continued From page 34 individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to obtain evidence of a negative . . . . . examination and freedom from communicable statement from a health care provider for two (Staff D and Staff E) of six sampled employees. Findings Included: A record review for Staff D was conducted on . . . . . and revealed that she was hired on . . . . . The record review further revealed that Staff D personell file did not include any documentation from a Health Care Provider stating that she was free from signs/ symptoms of tuberculos and a one-time statement confirming she was free from communicable . . . . . . A record review for Staff E was conducted on and revealed that she was hired on . . . . . The record review further revealed that Staff E personell file did not include any	A 078		

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A 078	Continued From page 35 documentation from a Health Care Provider that she was free from signs/symptoms of tuberculos and a one-time statement confirming she was free from communicable . The above findings were shared during an inteview with the facility's Executive Director (ED) on /20202 at 2:43 PM. During this interview the ED confirmed the missing doucmentation and stated," I couldnt find their documentation but I will be sure to get all of them up to date." Class III	A 078		