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
	AL11969322	A. BUILDING: _____ B. WING _____	02/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAS OVAS ALF CORP	1214 MEADOWBROOK DR WEST PALM BEACH, FL 33417

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced Relicensure survey was conducted on [redacted] at Las Ovas ALF Corp. The facility had deficiencies at the time of the survey.	A 000		
A 010 SS=D	429.26(.&9) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination shall be based upon an assessment of the strengths, needs, and preferences of the resident, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department. (2) A physician, physician assistant, or nurse practitioner who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interest in the facility. (9) A , ill resident who no longer meets the criteria for continued residency may remain in	A 010		

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A 010	Continued From page 1 the facility if the arrangement is mutually agreeable to the resident and the facility; additional care is rendered through a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident are being met. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to-medical examination by a health care provider at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in rule 59A-36.002, F.A.C. The results of the examination must be recorded on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days. (b) A resident requiring care of a may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care provider, 2. The condition is documented in the resident's record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care provider, the resident must be discharged from	A 010		

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A 010	Continued From page 2 the facility. (c) A , ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements a interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by:	A 010		

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A 010	Continued From page 3 Based on record review, observation and interview, the facility failed to ensure all residents had a completed Agency for Healthcare Administration Health Assessment (AHCA Form 1823) that was reflective of the residents care needs, for 1 of 2 sampled residents (Resident#5). The Findings Included: On . . . . . at 9:20 AM during the entrance conference, Resident#5 was identified as a Hospice resident. Review of Resident#5's record was reviewed and revealed, an admission date of . . . . . to the facility, with a diagnosis of . . . . . . Further review revealed, Resident#5's most recent AHCA form 1823 was completed on . Further review of the updated AHCA Form 1823 revealed, no documentation that Resident#5 was receiving Hospice services. Further review revealed, page 4 section B of the AHCA Form 18223, was left blank and no instructions for level of assistance needed for medications was documented. During an interview with the Administrator on . . . . . at 3:00 PM, he acknowledged the findings and provided no additional documentation for review. Class III	A 010		
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	A 054		

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A 054	Continued From page 4 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. (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 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 , 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 record signed by the facility staff for Administration of medication, for 1 of 6 sampled residents (Resident#5). The Findings Included: A review of Resident#5's medication observation record (MOR) revealed daily medication(s) for through , were	A 054		

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A 054	Continued From page 5 documented(signed) as given. During an interview with the Administrator at 3:00 PM, he revealed Resident#5 MOR's are being signed by the resident's daughter, as she is the person who administers the residents medication. During a interview on . . . . . at 3:10 PM, he acknowledged the findings. Class III	A 054		
AL241 SS=D	429.075( ); 59A-36.020(2) FAC LMH - Records 429.075 (3) A facility that has a limited mental health license must: (a) Have a copy of each mental health resident's community living support plan and the . . . . . agreement with the mental health care services provider or provide written evidence that a request for the community living support plan and the , agreement was sent to the Medicaid managed care plan or managing entity under contract with the Department of Children and Families within 72 hours after admission. The support plan and the agreement may be combined. (b) Have documentation provided by the department that each mental health resident has been assessed and determined to be able to live in the community in an assisted living facility that has a limited mental health license or provide written evidence that a request for documentation was sent to the department within 72 hours after admission. (c) Make the community living support plan available for inspection by the resident, the resident's legal guardian or health care surrogate, and other individuals who have a lawful basis for	AL241		

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AL241	Continued From page 6	AL241		

reviewing this document.
(d) Assist the mental health resident in carrying out the activities identified in the resident's community living support plan.
(4) A facility that has a limited mental health license may enter into a , agreement with a private mental health provider. For purposes of the limited mental health license, the private mental health provider may act as the case manager.

59A-36.020
(2) RECORDS.
(a) A facility with a limited mental health license must maintain an up-to-date admission and discharge log containing the names and dates of admission and discharge for all mental health residents. The admission and discharge log required in rule 59A-36.015, F.A.C., satisfies this condition provided that all mental health residents are clearly identified.
(b) Staff records must contain documentation that designated staff have completed limited mental health training as required by rule 59A-36.011, F.A.C.
(c) Resident records must include:
1. Documentation, provided by a mental health care provider within 30 days of the resident's admission to the facility, that the resident is a mental health resident as defined in section 394.4574, F.S., and that the resident is receiving social security , or supplemental security income and as follows:
a. An affirmative statement on the Alternate Care Certification for , ( ) form, CF-ES 1006, , which is hereby incorporated by reference and available for review at:

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AL241	Continued From page 7 http://www.flrules.org/Gateway/reference.asp?No=Ref-03988, that the resident is receiving SSI or SSDI due to a mental , . b. Written verification provided by the Social Security Administration that the resident is receiving SSI or SSDI for a mental . Such verification may be acquired from the Social Security Administration upon obtaining a release from the resident permitting the Social Security Administration to provide such information, or c. A written statement from the resident's case manager or other mental health care provider that the resident is an adult with severe and persistent mental . The case manager or other mental health care provider must consider the following minimum criteria in making that determination: (I) The resident is eligible for, is receiving, or has received mental health services within the last 5 years, or (II) The resident has been diagnosed as having a severe or persistent mental . 2. An appropriate placement assessment provided by the resident's mental health care provider within 30 days of admission to the facility that the resident has been assessed and found appropriate for residence in an assisted living facility. Such assessment must be conducted by a psychiatrist, clinical psychologist, clinical social worker, , , nurse, or an individual supervised by one of these professionals. a. Any of the following documentation that contains the name of the resident and the name, signature, date, and license number, if applicable, of the person making the assessment, meets this requirement: (I) Completed Alternate Care Certification for , , , ( ) form, CF-ES Form 1006,	AL241		

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AL241	Continued From page 8 (II) Discharge Statement from a state mental hospital completed no more than 90 days before admission to the assisted living facility provided it contains a statement that the individual is appropriate to live in an assisted living facility, or (III) Other signed statement that the resident has been assessed and found appropriate for residency in an assisted living facility. b. A mental health resident returning to a facility from treatment in a hopsital or crisis stabilization unit will not be considered a new admission and will not require a new assessment. However, a break in a resident's residency that requires the facility to execute a new resident contract or admission agreement will be considered a new admission and the resident's mental health care provider must provide a new assessment. 3. A Community Living Support Plan. Each mental health resident and the resident's mental health case manager must, in consultation with the facility administrator, prepare a plan within 30 days of the resident's admission to the facility or within 30 days after receiving the appropriate placement assessment in paragraph (2)(c), whichever is later, that: a. Includes the specific needs of the resident that must be met in order to enable the resident to live in the assisted living facility and the community, b. Includes the clinical mental health services to be provided by the mental health care provider to help meet the resident's needs, and the frequency and duration of such services, c. Includes any other services and activities to be provided by or arranged for by the mental health care provider or mental health case manager to meet the resident's needs, and the frequency and duration of such services and activities, d. Includes the _____ of the facility to facilitate and assist the resident in attending	AL241		

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AL241	Continued From page 9 and arranging transportation to for the services and activities identified in the plan that have been provided or arranged for by the resident's mental health care provider or case manager, e. Includes a description of other services to be provided or arranged by the facility, f. Includes a list of factors pertinent to the care, safety, and welfare of the mental health resident and a description of the signs and symptoms to the resident that indicate the immediate need for professional mental health services, g. Is in writing and signed by the mental health resident, the resident's mental health case manager, and the assisted living facility administrator or manager and a copy placed in the resident's file. If the resident refuses to sign the plan, the resident's mental health case manager must add a statement that the resident was asked but refused to sign the plan, h. Is updated at least annually or if there is a significant change in the resident's behavioral health, i. include the Agreement described in subparagraph (2)(c)4. If included, the mental health care provider must also sign the plan; and, j. Must be available for inspection to those who have legal authority to review the document. 4. Agreement. The mental health care provider for each mental health resident and the facility administrator or designee must prepare a written statement, within 30 days of the resident's admission to the facility or receipt of the resident's appropriate placement assessment, whichever is later. The statement: a. Provides procedures and directions for accessing emergency and after-hours care for	AL241		

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AL241	Continued From page 10 the mental health resident. The provider must furnish the resident and the facility with the provider's 24-hour emergency crisis telephone number; b. Must be signed by the administrator or designee and the mental health care provider, or by a designated representative of a Medicaid prepaid health plan if the resident is on a plan and the plan provides behavioral health services in section 409.912, F.S.; c. , cover all mental health residents of the facility who are clients of the same provider; and, d. , be included in the Community Living Support Plan described in subparagraph (2)(c)3. 5. Missing documentation 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 appropriate party. A documented request for such missing documentation made by the facility administrator within 72 hours of the resident's admission will be considered a good faith effort. The documented request must include the name, title, and phone number of the person to whom the request was made and must be kept in the resident's file. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to obtain required documentation for Limited Mental Health (LMH) resident admitted to the facility, and to maintain records for daily monitoring for 1 of 1 sampled residents (Resident#1) The Findings Included: On , on arrival to the facility, the facility Admission and Discharge log was revived and	AL241		

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AL241	Continued From page 11	AL241		

revealed Resident#1 was documented as a Limited Mental Health resident. Resident#1 was admitted to the facility on [redacted], with a diagnosis of [redacted], and [redacted]. Further review revealed, Resident#1 receives Social Security [redacted] Insurance, but does not receive Optional State Supplement, and there was no application on file. Further review of Resident#1's Community Living Support Plan and Community Agreement dated [redacted], had no attached documentation of a discharge statement form a state mental hospital completed 90 days prior to admission to the facility, and no documentation that assessed Resident#1's appropriateness for placement in a ALF. Further review of Resident#1's Community Living Support Plan dated [redacted] documents under special needs, that Resident#1 is [redacted] and requires daily [redacted] checks to monitor [redacted], to be implemented by the ALF. Review of the resident facility records reveal no [redacted] monitoring log for Resident#1. At this time during an interview with Staff A and the Administrator, they stated the resident conducts the [redacted], but it is not recorded or reported to a health care professional. There is also no physician order on file for daily [redacted] monitoring. At 1:30 PM during an interview with the Resident#1, she verified she checks her [redacted] almost every day, she reports it to the staff, but she does not record it. She states her [redacted] should be below 100, and she states it usually in the 80's or 90's. At 1:35 PM the [redacted] monitor memory was reviewed for Resident#1 [redacted] monitor. The last date in Memory is [redacted] at 8:10 AM Level 88, no memory for [redacted], Highest level saved in Memory was [redacted] Level 140. The [redacted] monitor does not have a year attached to the date, so this surveyor was unable to verify what

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AL241	Continued From page 12 year the level was saved. Review of Resident#1 Medication Observation Log documents Resident#1 takes P.O. . . . 1000 mg twice a day. During an interview on at 3:10 PM with the Administrator, he acknowledged the findings and provided no additional documentation for review. Class III	AL241		