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
	AL11964066	A. BUILDING: _____ B. WING _____	04/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOD'S VIP SENIOR HAVEN LLC	4681 SW 66TH AVENUE DAVIE, FL 33314

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced complaint survey, # 2020006767 was conducted on . . . . . /2020 at God's VIP Senior Haven, LLC. The facility had deficiencies found at the time of the visit.	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	A 010		

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A 010	Continued From page 1 the criteria for continued residency may remain in 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 [illegible]-to-[illegible] 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 [illegible] 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	A 010		

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A 010	Continued From page 2 provider, the resident must be discharged from 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.	A 010		

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A 010	Continued From page 3 This Statute or Rule is not met as evidenced by: Based on record review, observation and interview, it was determined the facility failed to monitor the continued appropriateness of placement, for 1 out of 9 residents that resides in the facility (resident #1).This was evidenced by the failure to transfer a bedbound resident with a worsening , , and requiring total care for activities of daily living(ADL) care to a higher level of care facility. The resident health assessment form did not accurately reflect the residents medical condition and needs. The findings include: In an observation of Resident #1 on at 8:30 AM, the resident was observed lying in a hospital bed, her upper and lower extremities were against her body. Resident #1 was on hospice services for 's and now on 24- hour crisis care for a further decline in condition. The hospice aide at the resident's bedside stated that Resident#1 required total care for all ADL care and the resident could no longer feed herself, requiring the staff to feed her a diet of pureed food. A collection bag was noted attached to the bedrail. The hospice aide stated, that Resident #1 had a pressure injury and the was to facilitate healing of the since the resident was . Review of Resident # 1 's medical record indicated the resident was admitted to hospice services on for diagnosis of 's . Review of the current Resident Health Assessment form dated on indicated the resident had medical	A 010		

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A 010	Continued From page 4 diagnoses including [illegible] 's [illegible], [illegible] and [illegible]. The form indicated the resident required assistance with all activities of daily living (ADL) care and required a pureed diet and thickened liquids. The form does not indicate that Resident #1 is being treated for a [illegible], or the use of an [illegible]. Review of a physician note dated on [illegible] indicated Resident #1 had a [illegible]. The note further indicated that hospice services would manage care for the resident. The note indicated the resident required a pureed diet and a [illegible] to manage the [illegible] healing. Review of Resident #1 hospice updated Plan of Care indicated evidence of progression to include that the resident had a decreased level of activity and was dependent for 6 of 6 ADLs. Resident #1 had [illegible] requiring pureed diet and thickened liquids, required [illegible] precautions and facility staff to feed the resident. Review of a hospice physician order dated on [illegible] indicated Resident #1 had a [illegible] and treatment was ordered and to reposition the resident every 2 hours, off loading both the [illegible] area and [illegible] lower extremities. Review of a hospice physician order dated on [illegible] indicated Resident #1 had a [illegible] and the hospice nurse was providing [illegible] care treatment 3 times a week and as needed. The resident was ordered continued [illegible] use for [illegible] healing.	A 010		

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A 010	Continued From page 5 Review of the hospice care nurse practitioner note for Resident # 1 dated on indicated the resident is bedbound, awake but . The note indicated that the resident requires with ADL care and has evidence of atrophy and further decline was noted. The resident has a for and to prevent . The note indicated that Resident #1 has a / that is full thickness loss of skin with 60% dark boggy and 40% tissue and is positive for undermining. The periwound is intact and margins are well defined. The note indicated that care is ordered for 3 x week and as needed. Review of the hospice nursing note dated on indicated Resident #1's measurements as , 5 x 3.5 x unknown cm and 100% . The note indicated that Resident #1 was placed on 24 hour nursing crisis care for poor nutritional intake, and care and monitoring. The note indicated the request for a care physician assessment for Resident #1's . Review of the hospice nursing note dated on indicated Resident #1's was now a with measurements of 5.5 x 7.0 x 1.5 cm and 25% and 75% with moderate noted. The note indicated that Resident #1 remained on 24 hour crisis care and was visited by the hospice care physician who evaluated the . In an interview with the hospice nurse on at 3 PM, she stated that Resident #1	A 010		

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A 010	Continued From page 6 remained on 24 hour crisis care to provide nursing care including monitoring of the , poor intake and care. She stated that the resident required total ADL care including staff feeding the resident. The nurse stated that the hospice care physician had evaluated the resident's . The hospice nurse stated that the resident would be discharged from crisis care within the next few days and she expected the facility unlicensed care staff could provide the additional care and monitoring of the resident, including the care. The nurse was questioned, if she felt the resident was appropriate for this facility and she stated that the resident would be better off at a facility offering higher level of care due to the resident's decline, worsening condition and requirement. In an interview with the Administrator on at 12:00 PM, she stated that she was not aware that Resident #1 would be discharged from 24 hospice crisis care in the next few days. She stated that the facility did not employ nurses or have any nursing capabilities to care for the resident. She stated that Resident #1 medical condition had declined further and the had not improved. The Administrator stated that the facility could not begin to meet the resident's current care needs and she would need to discuss discharge options for the resident. Class III	A 010		
A 030 SS=G	59A-36.007(6) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007	A 030		

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A 030	Continued From page 7 (6) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to rule 59A-36.006, F.A.C. (b) In accordance with section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; [illegible] Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- [illegible] or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage;	A 030		

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A 030	Continued From page 8 4. Resident elopement; 5. Reporting resident , neglect, and ; 6. Administrative and housekeeping schedules and requirements; 7. control, sanitation, and universal precautions; and, 8. The requirements for coordinating the delivery of services to residents by third party providers. (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. (g) In addition to the requirements of section 429.41(1)(k), F.S., the use of physical by a facility on a resident must be reviewed by the resident's physician annually. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance, is not considered a physical . 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges	A 030		

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A 030	Continued From page 9 guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at	A 030		

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A 030	Continued From page 10 regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall	A 030		

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A 030	Continued From page 11	A 030		

establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups.
(2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida.

429.27 Property and personal affairs of residents.-
(1)(a) A resident shall be given the option of using his or her own belongings, as space permits;

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A 030	Continued From page 12 choosing his or her roommate; and, whenever possible, unless the resident is adjudicated [illegible] or [illegible] under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to safe guard the residents well being by failing to follow current [illegible] control standards related to the COVID-19 recommendations set forth by Centers for [illegible] Control and Prevention (CDC). The facility failed to screen all visitors for the presence of [illegible] and symptoms of COVID-19 when entering the building. Coronavirus 2019 (COVID-19) CDC Guidance "Considerations When Preparing for COVID-19 in Assisted Living Facilities", updated [illegible] indicated to- "Designate one or more facility employees to actively screen all visitors and personnel, including essential consultant personnel, for the presence of and symptoms of COVID-19 before starting each shift/when they enter the building." The findings include: On at 6:00 AM, the surveyor along with	A 030		

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A 030	Continued From page 13 a state department representative approached the facility front door and rang the bell for admittance to the facility. A Caregiver opened the door and allowed immediate access into the facility. The Caregiver did not make any attempt to screen for or inquire about any symptoms of COVID-19. In an interview with the Caregiver on at 7:00 AM, she stated that she had been inserviced about the CDC guidance regarding admission into the facility but she didn't believe she needed to follow the CDC recommendations since the surveyor and department staff were state employees. When she was questioned how the facility was screening visitors, she stated that the handheld thermometer and screening log book were locked in the Administrator's office. The caregiver was observed to make an attempt to open the office door but was unable to gain access. In an interview with the Assistant Administrator on at 8:00 AM, he stated that the facility was following the CDC recommendations for COVID-19 and was actively screening staff and any essential personnel when they entered the facility. He was informed that the Caregiver had failed to screen the surveyor and department staff according to CDC recommendations. He stated that the Caregiver had been trained on the CDC recommendations and she was aware of the facility policy. The Assistant Administrator was observed entering into the office and returning with a held thermometer device along with the screening log book to screen the visitors. Class II	A 030		

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	AL11964066	A. BUILDING: _____ B. WING _____	04/23/2020

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A 053	Continued From page 14	A 053		
A 053 SS=D	59A-36.008(4) FAC Medication - Administration (4) MEDICATION ADMINISTRATION. (a) For facilities that provide medication administration, a staff member licensed to administer medications must be available to administer medications in accordance with a health care provider's order or prescription label. (b) Unusual reactions to the medication or a significant change in the resident's health or behavior that may be caused by the medication must be documented in the resident's record and reported immediately to the resident's health care provider. The contact with the health care provider must also be documented in the resident's record. (c) Medication administration includes conducting any examination or other procedure necessary for the proper administration of medication that the resident cannot conduct personally and that can be performed by licensed staff. (d) A facility that performs clinical laboratory tests for residents, including [illegible] testing, must be in compliance with the federal Clinical Laboratory Improvement Amendments of 1988 (CLIA) and chapter 483, part I, F.S. A valid copy of the State Clinical Laboratory License, if required, and the federal CLIA Certificate must be maintained in the facility. A state license or federal CLIA certificate is not required if residents perform the test themselves or if a third party assists residents in performing the test. The facility is not required to maintain a State Clinical Laboratory License or a federal CLIA Certificate if facility staff assist residents in performing clinical laboratory testing with the residents' equipment. Information about the State Clinical Laboratory License and federal CLIA Certificate is available from the Laboratory Unit, Agency for Health Care	A 053		

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A 053	Continued From page 15 Administration, 2727 Mahan Drive, Mail Stop 32, Tallahassee, FL 32308; telephone (850)412-4500. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that unlicensed staff only provided assistance with self -administration of medications. The facility failed to have a licensed staff member administer medications to 2 of 5 sampled residents (Residents # 1 and #2). The findings include: 1) In an observation of Resident #1 on . . . . . at 8:30 AM the resident was observed lying in a hospital bed, her upper and lower extremities were . . . . . against her body. Resident #1 was on hospice 24 hour crisis care for a further decline in condition. The hospice aide at the bedside stated that the resident required total care for all ADL care and the resident could no longer feed herself,requiring the staff to feed her a diet of pureed food. In an observation and interview with the facility aide,(Med Tech) whose assignment was to assist the residents with self- administration of their medication on at 8:35 AM, stated that Resident # 1 had difficulty swallowing and was ordered a pureed diet to reduce the risk of . . . . . She was observed to crush up the medications for Resident #1 and place the crushed medications into applesauce then spoon fed the applesauce to the resident. The med tech stated that Resident #1 is not able to feed herself or hold a spoon. The med tech stated that she was not aware that she should not be administering medication to Resident #1 as she is	A 053		

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A 053	Continued From page 16 not licensed to perform this task. Review of Resident # 1 's medical record indicated the resident was admitted to hospice services on for diagnosis of 's . Review of the current Resident Health Assessment form dated on indicated the resident had medical diagnoses including 's , , and . The form indicated the resident required assistance with all activities of daily living care and required a pureed diet and thickened liquids. Review of Resident #1's Medication Observation Record (MOR) indicated that the resident is prescribed the following medications by at 8 AM daily, Septra DS, 0.125 mg, 12.5 mg, 30 mg, 100 mg, 325 mg , 500 mg, 20meq, 8.6 mg, and 1 mg. Review of Resident #1 hospice updated Plan of Care indicated evidence of progression to include that the resident had a decreased level of activity and was dependent for 6 of 6 ADLs. Resident #1 had requiring pureed diet and thickened liquids, required precautions and facility staff to feed the resident. Review of the Hospice nursing note dated on indicated the resident required total care for all ADL care, and a pureed diet and thickened liquids to reduce the risk of . Facility staff was to assist Resident #1 to eat her meals. In an interview with the hospice nurse on	A 053		

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A 053	Continued From page 17 . . . . . at 3 PM she stated that Resident #1 remained on 24 hour crisis care to provide nursing care including monitoring of the . . , . . , poor intake and . . . . . care. She stated that the resident required total ADL care, including staff feeding the resident. 2) In an observation of Resident #2 on . . . . . at 8:50 AM, the resident was observed lying in a hospital bed, her extremities were stiff. The resident was reaching out and grabbing the . . . . of the caregiver who was attempting to feed the resident her breakfast meal. The caregiver stated that Resident#2 required total care for all ADL care and the resident required the staff to feed her meals. In an observation and interview with the facility aide,(Med Tech) whose assignment was to assist the residents with self- administration of their medication on . . . . . at 8:55 AM, stated that Resident #2 had difficulty taking medication by . . . and was ordered medications to be crushed and placed into applesauce. The Med Tech was observed to crush the medications, place the crushed medications into applesauce and then spoon feed Resident #2 the applesauce mixture. The Med Tech stated that Resident #2 is not able to feed herself or hold a spoon. The Med Tech stated that she was not aware that she should not be administering medication to Resident #2 as she is not licensed to perform this task. Review of Resident #2's . . . . . Medication Observation Record (MOR) indicated that the resident is prescribed the following medications by . . . . at 8 AM daily, ... 0.5 mg, Risperidol 2 mg, ... 25 mg, and . . . . . 125 mg x 2 caps.	A 053		

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A 053	Continued From page 18 In an interview with the Administrator on [redacted] at 12:00 PM observations of the unlicensed Med Tech during med pass for Resident #1 and #2 were discussed. The Administrator confirmed that both Resident #1 and #2 required staff assistance to be fed and she stated that she did not have a licensed nurse on staff to administer the resident's medications. Class III	A 053		