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
	AL11911143	A. BUILDING: _____ B. WING _____	04/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHN KNOX VILLAGE OF CENTRAL F	101 NORTHLAKE DRIVE ORANGE CITY, FL 32763

(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 A complaint investigation (complaint number 2020007407) and Control Covid 19 survey was conducted at John Knox Village of Central Florida Assisted Living Facility on , -30,2020. The facility had deficiencies at the time of the survey, including a Class I citation for 0056, Medication Labelling and Orders.	A 000		
A 030	59A-36.007(6) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (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; , 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- or 1(800)962-2873. The	A 030		

AHCA Form 3020-0001

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

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A 030	Continued From page 1 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. [illegible] and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and [illegible]; 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	A 030		

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A 030	Continued From page 2 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 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	A 030		

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A 030	Continued From page 3 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 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 [illegible] for health care services, the provision of or arrangement of transportation to health care [illegible], 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 [illegible], the guardian shall be	A 030		

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A 030	Continued From page 4 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 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	A 030		

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A 030	Continued From page 5 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; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated . . . . , ... or . . , ... 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 record reviews and interviews, the facility failed to implement its grievance policy for 1 of 3 residents sampled (Resident #1) regarding a grievance filed by a family member that the facility failed to obtain a prescription medication for the resident. The findings include: On at 3:00 PM, the Administrator	A 030		

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A 030	Continued From page 6	A 030		

reported a grievance was received for Resident #1 on by her son. The grievance was related to the resident returning from a dental without the prescription for an ( ) that the son stated was prescribed on . When the resident returned to the facility, there was a prescription for a Periogard rinse. Records were requested from the dental office to determine if Resident #1 was prescribed the . The Administrator stated, "I have not heard anything from the dental office yet." The Administrator reported she reached out to the dental office for information on , 27 days after the grievance was filed.

Record review conducted for Resident #1 revealed an admission date of . The Health Assessment (Form 1823) noted the resident was independent in activities of daily living (ADLs), legally , used a walker and had some memory loss. On Resident #1 went to an endodontist for a root canal and received a prescription for , 150 milligrams (mg) every 6 hours until gone (30 tablets). She received the as ordered. On Resident #1 went to a dental with a home health aide, but was sent straight to the endodontist. Records from the endodontist showed a new prescriptions for , 150 mg (30 tablets) every 6 hours until gone, with Periogard (16 ounces) ounce (oz.) twice a day and rinse for 30 seconds until the area is healed, with a follow up on . The endodontist documented in his notes the , 150 mg was prescribed and he "advised residents nurse to start as soon as possible." The resident returned to the facility with the home health aide and the paperwork.

A nursing note on at 12:58 PM

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A 030	Continued From page 7 indicated the resident returned from the dental , , , but ended up seeing the endodontist with a new order received and noted for Periogard oz. twice a day, rinse for 30 seconds with a return , , , on , at 11:00 AM. was not mentioned in the nurse's notes. A review of the Medication Observation Record for revealed was not documented to be given after the dental , , on . Additional notes revealed the resident's follow-up , , was changed to . The Administrator explained at 1:45 PM on that the son's first grievance was documented on and he continued it again on after his mother on . The concern was his mother did not receive the ordered on the dental visit for . The Administrator stated, "Due to resources, I started the investigation on ." When asked the time frame for resolution of grievances, the Administrator replied, "Grievances are usually resolved within a few days to a week". Regarding why the grievance was not resolved, the Administrator said the resident was out of the facility, she was trying to contact the son, secure information about the surgery, and trying to be sensitive to the family. She also was caught up with COVID-19 and all of those procedures. A grievance policy was requested. The Grievance Policy, dated , noted "a prompt response would be given to all grievances from residents or responsible party with documentation to substantiate an action." Under "Procedure", it was noted "the grievance will be investigated to determine validity, and a solution to the grievance will be provided to the family	A 030		

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A 030	Continued From page 8	A 030		

within a period of 24 hours and no more than 30 days (time period depends on the extent of the investigation). All parties are to be aware that the situation is being addressed and investigated. Upon resolution a meeting shall be conducted with the resident or family to be assured that the resident is satisfied with the end result." Photographic evidence obtained.

Interview with the Administrator on at 4:32 PM revealed she thought the grievance was resolved on after speaking to Resident #1's son. He contacted her again on concerning his mother not receiving the on from the dental office, and she continued the grievance. It was the same situation so it was classified as one grievance.

The home health aide who accompanied Resident #1 on was interviewed on via telephone at 4:50 PM. She reported during checkout, the dentist told her to tell the nurse to rinse the resident's out several times a day and start the immediately, and tell the nurse to call him for more detailed instructions. She reported the visit's paperwork was given to the nurse on the 100 floor (Employee B), and she told the nurse Resident #1 needed to be started on the right away and to call the doctor for detailed instructions.

The grievance log was received via email on . The grievance log documented the grievances reported by Resident #1's son. On a grievance stated, "Family member voiced concern of mother returning from appt. with a prescription being filled." The solution stated "see attached" and was listed as resolved in one day, . The attached document

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A 030	Continued From page 9 was undated and indicated record reviews were conducted, but there was no indication interviews were conducted with staff or the home health companion, or that the dental offices were consulted to verify accuracy of prescriptions. Additionally, a note stated Resident #1 had a prescription filled for [redacted] for 7 days, ending on [redacted], although the resident was discharged on [redacted]. The grievance filed on [redacted] did not have a resolution date on the grievance log. This grievance was for "concerns he had during his mother's stay." The undated attachment detailing the investigation listed it as "ongoing." The summary of the investigation showed that dental records were requested on [redacted] and received on [redacted]. This form summarized the dental records from Resident #1's visit on [redacted] as "uneventful according to the office indicating that they did not see any negative effect of the missed prescription." Photographic evidence obtained. Review of the handwritten progress notes from the endodontist's office documenting the visit on [redacted] read, "Area still [redacted], Dr. will call general dentist to discuss [redacted] still very mobile, [redacted] has a poor prognosis..." These notes were received by the facility on [redacted] and were not included in the summary of the grievance investigation. Another note dated [redacted] stated that Resident #1 was hospitalized on [redacted] and the facility failed to fill the prescription on [redacted], "only [redacted] rinse." Photographic evidence obtained. Class II	A 030		

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A 056	Continued From page 10	A 056		
A 056	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 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	A 056		

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A 056	Continued From page 11	A 056		

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:
1. Practitioner's name,
2. Resident's name,
3. Date dispensed,
4. Name and strength of the drug,
5. Directions for use; and,

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A 056	Continued From page 12 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 record review and interviews the facility failed to ensure necessary prescriptions were filled timely for 1 of 3 sampled residents (Resident #1) resulting in a significant decline and hospitalization. The findings include: 1. Resident #1's record showed she was admitted on [redacted]. Her Health Assessment (Form 1823) was signed on [redacted] and indicated she needed assistance with self-administration of medications. Her contract indicated she would receive services including nursing supervision (a nurse on duty 24 hours a day) and medication management. On [redacted], Resident #1 went to an endodontist for a root canal and received an order for [redacted] (an [redacted]) 150 milligrams (mg), every 6 hours until gone (30 tablets). She received the [redacted] as ordered. Resident #1 returned to the endodontist on [redacted]. After examination, the endodontist noted [redacted] #27 was still very [redacted], and [redacted] #22 would require a root canal. The [redacted] needed to be under control before starting on [redacted] #22. [redacted] 150 mg (30 tablets) every 6 hours was ordered again, along with Periogard (16 ounces) [redacted] ounce (oz.). The endodontist documented in his notes that [redacted] 150 mg was prescribed and he advised Resident #1's	A 056		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 056	Continued From page 13 nurse to start it as soon as possible. Progress notes dated [redacted] at 12:58 PM noted Resident #1 went to the general dentist that day, but then went to the endodontist who performed her root canal. The endodontist ordered Periogard [redacted] oz. twice a day, rinse for 30 seconds, and to return at a follow up [redacted] was not mentioned in the nurse's notes. A review of the Medication Observation Record for [redacted] revealed [redacted] was not documented as given after the dental [redacted] on [redacted]. An order summary report for [redacted] only listed the [redacted] doses from [redacted] to [redacted]. On [redacted] at 4:50 PM, an interview was conducted with the Home Health Aide who accompanied Resident #1 to the endodontist on [redacted]. She reported the resident was transferred from one dentist office to another dentist on [redacted]. The aide waited in the lobby during the examination. She reported during checkout, the endodontist told her to relay a message to the facility's nurse to rinse the resident's [redacted] out several times a day and start the [redacted] immediately, and tell the nurse to call him for more detailed instructions. She reported the paperwork received at the endodontist visit was given to the nurse on the 100 floor (Employee B), and she told the nurse Resident #1 needed to be started on the right away, and to call the doctor for detailed instructions. When asked who she returned the paperwork to when a resident returns from an [redacted], the aide replied, "I always return the paperwork to the nurses." An interview was conducted with Employee B, Licensed Practical Nurse (LPN) on [redacted] at	A 056		

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A 056	Continued From page 14 5:25 PM. Employee B reported she received the paperwork from the companion regarding the dental . , , ... for Resident #1, and discussed the rinse. The resident had a follow up , , ... Employee B called the general dentist and they stated Resident #1 was sent to the endodontist from their visit. Employee B was asked why she called the dentist and she replied, "I was not sure why I had a prescription from the endodontist." She reported she did not then call the endodontist because she had the prescription for the Periogard rinse with his name on it. The prescription was faxed to the pharmacy. Photographic evidence obtained. On at 10:10 AM, the endodontist's office manager confirmed the prescriptions and follow up , , details were given to the aide following Resident #1's . , , ... on . . A review of the medical record revealed Resident #1 went . . . to the endodontist on . . . . . with another Home Health Aide. There were no new orders in the record from that visit. Notes from the endodontist revealed the was . . . . . , "very mobile, ... , and due to mobility, the has a poor prognosis" and . . . . . was recommended. Facility progress notes indicated that on , the resident was having difficulty swallowing her pills and having an issue with keeping her top . . in. Photographic evidence obtained. A progress note documented on . . . . . at 8:09 AM that Resident #1 informed staff that "something wasn't right." When Employee B entered the apartment, the resident was trying to talk, but was hard to understand, having difficulty swallowing, and her . looked short. The	A 056		

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A 056	Continued From page 15 breakfast tray was untouched. The med tech informed Employee B the resident was unable to take her medications "today or yesterday; even after putting them in applesauce." Resident #1 was sent to the hospital. On [redacted] at 4:16 PM Employee B documented in the progress notes she contacted the hospital nurse. The RN reported Resident #1 would be transferred to another hospital to have surgery. The resident's [redacted] revealed a [redacted] under the [redacted] with an [redacted] and thickening of the epiglottis. The endodontist's progress note dated [redacted] stated treatment was discussed with Resident #1's son, that she was hospitalized, and the facility failed to fill the [redacted] prescription on [redacted]. Only the [redacted] rinse was filled. Photographic evidence was obtained. A review of the job description for LPN noted in the job summary, "The primary purpose is to provide routine nursing care in accordance with established polices and procedures and current state regulations, as well as supervising personal care assistants, certified nursing assistants and medications technicians." Under essential functions and responsibilities, the following was listed: provide nursing care in accordance with physician orders and established plan of care to assure continuity and to meet the individual needs of the resident while assuring safety at all time. Photographic evidence obtained. 2. Records for Resident #1 showed that on on [redacted] a fax was sent to the Medical Director requesting [redacted] for a complaint of generalized [redacted] as well as [redacted]. The records indicated no "as needed" (prn) [redacted] medication was currently available, and the oncoming shift would be notified for follow up. Photographic evidence	A 056		

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A 056	Continued From page 16 was obtained. It was not until . . . . . , after resident was in hospital, that the order for , 500 mg orally every 6 hours was received. The Administrator explained in an interview at 4:36 PM on that Employee B, LPN, has a process she follows for ordering , . medication from the physician. If a resident needed , . medication that wasn't already ordered, they would contact the physician. They would follow up in a reasonable amount of time if there had not been any order received. An interview was conducted with Employee B, LPN, on . . . . . at 9:36 AM concerning the request for a , medication if needed for a resident. Employee B reported the physician would receive a request for , medication by fax, and if there was no answer, staff would follow up the next day. If there was still no response, staff would call the physician or answering service. She confirmed on a fax was sent to the physician for . . . , . for Resident #1 and there was no response, and no one followed up. Class I	A 056		
A 077	429.176 FS; 429.52(.),59A-36.01(1) FAC Staffing Standards - Administrators 429.176 Notice of change of administrator.-If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more	A 077		

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A 077	Continued From page 17 than 120 consecutive days without an administrator who has completed the core educational requirements. 429.52 (4) A new facility administrator must complete the required training and education, including the competency test, within 90 days after date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19. Administrators licensed in accordance with part II of chapter 468 are exempt from this requirement. Other licensed professionals may be exempted, as determined by the agency by rule. (5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years. 59A-36.010 (1) ADMINISTRATORS. Every facility must be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents as required by chapters 408, part II, 429, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter. (a) An administrator must: 1. Be at least [illegible]; 2. If employed on or after [illegible], have, at a minimum, a high school diploma or G.E.D.; 3. Be in compliance with Level 2 background screening requirements pursuant to sections 408.809 and 429.174, F.S.; 4. Complete the core training and core competency test requirements pursuant to rule	A 077		

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A 077	Continued From page 18 59A-36.011, F.A.C., no later than 90 days after becoming employed as a facility administrator. Administrators who attended core training prior to , are not required to take the competency test unless specified elsewhere in this rule; and, 5. Satisfy the continuing education requirements pursuant to rule 59A-36.011, F.A.C. Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect on the date the non-compliance is discovered by the agency or the department. (b) In the event of extenuating circumstances, such as the of a facility administrator, the agency may permit an individual who otherwise has not satisfied the training requirements of subparagraph (1)(a)4. of this rule, to temporarily serve as the facility administrator for a period not to exceed 90 days. During the 90 day period, the individual temporarily serving as facility administrator must: 1. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C.; and, 2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility. (c) Administrators may supervise a maximum of either three assisted living facilities or a group of facilities on a single campus providing housing and health care Administrators who supervise more than one facility must appoint in writing a separate manager for each facility. However, an administrator supervising a maximum of three assisted living facilities, each licensed for 16 or fewer beds and all within a 15 mile of each other, is only required to appoint two managers to assist in the operation and maintenance of those	A 077		

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A 077	Continued From page 19 facilities. (d) An individual serving as a manager must satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements as an administrator pursuant to paragraph (1)(a) of this rule. Managers who attended the core training program prior to , , , , , are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as a manager of more than a single facility, except as provided in paragraph (1)(c) of this rule, and may not , serve as an administrator of any other facility. (e) Pursuant to section 429.176, F.S., facility owners must notify the Agency Central Office within 10 days of a change in facility administrator on the Notification of Change of Administrator form, AHCA Form 3180-1006, , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-09393. This Statute or Rule is not met as evidenced by: Based on record review and interviews the facility failed to ensure appropriate care and services were provided, evidenced by the failure to ensure medications were filled timely, failure to monitor and follow up on a health status change, and failure to investigate a grievance according to their own policy and procedure for 1 of 3 sampled residents (Resident #1). The findings include: Record review conducted for Resident #1 revealed an admission date of . The	A 077		

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A 077	Continued From page 20	A 077		

Health Assessment (Form 1823) noted the resident was independent in activities of daily living (ADLs), legally , used a walker and had some memory loss. On Resident #1 went to an endodontist for a root canal and received a prescription for , 150 milligrams (mg) every 6 hours until gone (30 tablets). She received the as ordered. On Resident #1 went to a dental , , with a home health aide, but was sent straight to the endodontist. Records from the endodontist showed new prescriptions for , , 150 mg (30 tablets) every 6 hours until gone, with Periogard (16 ounces) ounce (oz.) twice a day. There was also an order for a follow up , , . The endodontist documented in his notes the , 150 mg was prescribed and he "advised residents nurse to start as soon as possible." Photographic evidence was obtained. The resident returned to the facility with the home health aide and the paperwork.

A nursing note on at 12:58 PM indicated the resident returned from the dental , , but ended up seeing the endodontist. The order for the rinse and follow up , , were mentioned, but , was not in the nurse's notes. Photographic evidence obtained. A review of the Medication Observation Record for revealed , was not documented to be given after the dental , , on . Additional notes revealed the resident's follow-up , , was changed to .

Employee B, an LPN, explained at 2:24 PM on that she was informed on /202 that Resident #1 could speak but was was having difficulty swallowing her pills. She was worried

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A 077	Continued From page 21 she had had a [illegible]. When she arrived to work the next day, on [illegible], Resident #1 was sent out via 911 and did not return. She was admitted for an [illegible] under her [illegible] and required surgery. Facility records indicated she [illegible] on [illegible] under the care of hospice. On [illegible] at 3:00 PM, the Administrator reported a grievance was received for Resident #1 on [illegible] by her son. The grievance was related to the resident returning from a dental [illegible] without the prescription for an [illegible] ([illegible]) that the son stated was prescribed on [illegible]. When the resident returned to the facility, there was a prescription for a Periogard rinse. Records were requested from the dental office to determine if Resident #1 was prescribed the [illegible]. The Administrator stated, "I have not heard anything from the dental office yet." The Administrator reported she reached out to the dental office for information on [illegible], 27 days after the grievance was filed. She had not interviewed the home health aide who went with Resident #1 on [illegible]. At 4:36 PM on [illegible], she explained she had just received the dental records and discovered an order for [illegible] written on [illegible]. The Administrator explained at 1:45 PM on [illegible] that the son's first grievance was documented on [illegible] and he continued it again on [illegible] after his mother [illegible] on [illegible]. The concern was similar, about his mother's order for [illegible] on [illegible]. The Administrator stated, "Due to resources, I started the investigation on [illegible]." When asked the time frame for resolution of grievances, the Administrator replied, "Grievances are usually resolved within a few days to a week". Regarding why the grievance was not resolved, the	A 077		

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A 077	Continued From page 22 Administrator said the resident was out of the facility, she was trying to contact the son, secure information about the surgery, and trying to be sensitive to the family. She also was caught up with COVID-19 and all of those procedures. A grievance policy was requested. The Grievance Policy, dated , noted "a prompt response would be given to all grievances from residents or responsible party with documentation to substantiate an action." Under "Procedure", it was noted "the grievance will be investigated to determine validity, and a solution to the grievance will be provided to the family within a period of 24 hours and no more than 30 days (time period depends on the extent of the investigation). All parties are to be aware that the situation is being addressed and investigated. Upon resolution a meeting shall be conducted with the resident or family to be assured that the resident is satisfied with the end result." Photographic evidence obtained. Progress notes for show that Employee C, LPN documented the resident complained of a and but that upon examination the and were not present. Later in the shift, Resident #1 was sent to the emergency room (ER) for evaluation following a , as documented by Employee D, LPN. At 1:58 PM on Employee D confirmed Resident #1 and hit her and was sent right after getting staples in the ER. She said Resident #1 had a dry couch that was getting worse, where she was having problems swallowing. She said she noticed the getting worse but thought the hospital would also notice the and treat it.	A 077		

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A 077	Continued From page 23 Employee D explained that if Resident #1 couldn't swallow her pills it would be a major change and she would need to go to the hospital to be treated. A facility Medication Tech, Employee E, stated at 2:49 PM on [redacted] that she recalled Resident #1 experiencing difficulty swallowing pills whole, as was her norm, prior to her discharge. She stated she reported it to a nurse. The home health aide who accompanied Resident #1 on [redacted] was interviewed on [redacted] via telephone at 4:50 PM. She reported during checkout, the dentist told her to tell the nurse to rinse the resident's [redacted] out several times a day and start the [redacted] immediately, and tell the nurse to call him for more detailed instructions. She reported the visit's paperwork was given to the nurse on the 100 floor (Employee B), and she told the nurse Resident #1 needed to be started on the [redacted] right away and to call the doctor for detailed instructions. The grievance log was received via email on [redacted]. The grievance log documented the grievances reported by Resident #1's son. On [redacted] a grievance stated, "Family member voiced concern of mother returning from appt. with a prescription being filled." The solution stated "see attached" and was listed as resolved in one day, [redacted]. The attached document was undated and indicated record reviews were conducted, but there was no indication interviews were conducted with staff or the home health aide, or that the dental offices were consulted to verify accuracy of prescriptions. Additionally, a note stated Resident #1 had a prescription filled for [redacted], for 7 days, ending on [redacted],	A 077		

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A 077	Continued From page 24 although the resident was discharged on . Photographic evidence obtained. The grievance filed on did not have a resolution date on the grievance log. This grievance was for "concerns he had during his mother's stay." The undated attachment detailing the investigation listed it as "ongoing." The summary of the investigation showed that dental records were requested on and received on . This form summarized the dental records from Resident #1's visit on as "uneventful according to the office indicating that they did not see any negative effect of the missed prescription." Photographic evidence obtained. Review of the handwritten progress notes from the endodontist's office documenting the visit on read, "Area still , Dr. will call general dentist to discuss . still very mobile, has a poor prognosis..." These notes were received by the facility on and were not included in the summary of the grievance investigation. Another note dated stated that Resident #1 was hospitalized on and the facility failed to fill the prescription on , "only rinse." Photographic evidence obtained. During an interview on at 3:47 PM, the Administrator explained that the facility's Administration has been discussing the process for outside and what the best practice should be moving forward. They had not yet implemented any changes to their processes yet because people were not attending outside at the moment. She explained how they were planning to start an audit and what education could be started but at the time of the survey, corrective actions had not yet been	A 077		

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A 077	Continued From page 25 implemented. She stated they were contemplating filing an adverse incident report. She acknowledged she still needed to interview the aide who accompanied Resident #1 to the . . . . . on . . . . . . An email was received on . . . . . that contained an attachment of an adverse incident report. The incident report listed a lengthy summary of the circumstances of the incident. In the sections titled "analysis of the incident" and "corrective action summary" were both blank. Photographic evidence obtained. Class II .	A 077		
A 165	429.23(&) FS; 59A-36.016 FAC Risk Mgmt & QA; Adverse Incident Report 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the	A 165		

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A 165	Continued From page 26 resident's condition and results in: 1. ; 2. or damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, by electronic mail, facsimile, or United States mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, by electronic mail, facsimile, or United States mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) , neglect, or must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459,	A 165		

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	AL11911143	A. BUILDING: _____ B. WING _____	04/30/2020

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A 165	Continued From page 27	A 165		

chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply.
(8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board.
(9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board.
(10) The agency may adopt rules necessary to administer this section.

59A-36.016 Adverse Incident Report.
(1) INITIAL ADVERSE INCIDENT REPORT. The preliminary adverse incident report required by section 429.23(3), F.S., must be submitted within 1 business day after the incident pursuant to rule 59A-35.110, F.A.C., which requires online reporting.
(2) FULL ADVERSE INCIDENT REPORT. For

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A 165	Continued From page 28 each adverse incident reported in subsection (1), above, the facility must submit a full report within 15 days of the incident. The full report must be submitted pursuant to rule 59A-35.110, F.A.C., which requires online reporting. This Statute or Rule is not met as evidenced by: Based on record review and interviews the facility failed to timely file an adverse incident report for 1 of 1 residents (Resident #1) who was hospitalized after not receiving an (Clindimycin) ordered after a dental . The findings include: An interview was conducted with the Administrator on at 11:32 AM. She reported the facility did not have any adverse incidents. Record review conducted for Resident #1 revealed an admission date of . The Health Assessment (Form 1823) noted the resident was independent in activities of daily living (ADLs), legally , used a walker and had some memory loss. On Resident #1 went to an endodontist for a root canal and received a prescription for , 150 milligrams (mg) every 6 hours until gone (30 tablets). She received the as ordered. On Resident #1 went to a dental with a home health aide, but was sent straight to the endodontist. Records from the endodontist showed a new prescriptions for , 150 mg (30 tablets) every 6 hours until gone, with Periogard (16 ounces) ounce (oz.) twice a day and rinse for 30 seconds until the area is healed, with a follow up on . The endodontist documented in his	A 165		

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A 165	Continued From page 29 notes the [redacted] 150 mg was prescribed and he "advised residents nurse to start as soon as possible." Photographic evidence was obtained. The resident returned to the facility with the home health aide and the paperwork. A nursing note on [redacted] at 12:58 PM indicated the resident returned from the dental [redacted], but ended up seeing the endodontist with a new order received and noted for the [redacted] rinse and follow up [redacted]. The [redacted] was not mentioned in the nurse's notes. A review of the Medication Observation Record for [redacted] revealed [redacted] was not documented to be given after the dental [redacted] on [redacted]. Additional notes revealed the resident's follow-up [redacted] was changed to [redacted]. Photographic evidence was obtained. Employee B, an LPN, explained at 2:24 PM on [redacted] that she was informed on [redacted] that Resident #1 could speak but was was having difficulty swallowing her pills. She was worried she had had a [redacted]. When she arrived to work the next day, on [redacted], Resident #1 was sent out via 911 and did not return. She was admitted for an [redacted] under her [redacted] and required surgery. Facility records indicated she [redacted] on [redacted] under the care of hospice. An interview was conducted with the home health aide on [redacted] via telephone at 4:50 PM. The aide reported during checkout, the endodontist told her to tell the nurse to rinse the resident's [redacted] out several times a day and start the [redacted] immediately, and tell the nurse to call him for more detailed instructions. She reported the paperwork was given to the nurse on 100 floor (Employee B), and she told the nurse	A 165		

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A 165	Continued From page 30 Resident #1 needed to be started on the [redacted] right away and to call the doctor for detailed instructions. She confirmed the procedure is to always return paperwork to the nurses. An interview was conducted with Employee B, Licensed Practical Nurse (LPN) on [redacted] at 5:25 PM. Employee B reported she did receive the paperwork from the companion regarding the dental [redacted] for Resident #1, and discussed the rinse. The resident had a follow up [redacted] as well. Employee B called the general dentist's office, who informed her Resident #1 was sent to the endodontist. Employee B confirmed she did not then call the endodontist, she said it was because she had the prescription for the Periogard rinse with his name on it. The prescription was faxed to the pharmacy. A review of the medical record revealed resident went to the endodontist on with another home health aide. Notes from the visit revealed the was very mobile, [redacted] and due to mobility the [redacted] has a poor prognosis and is recommended at this time. The area was still [redacted]. Facility nursing notes indicated the resident was having difficulty swallowing her pills on [redacted] and having an issue with keeping her top in. Photographic evidence obtained. Progress notes for [redacted] show that Employee C, LPN documented the resident complained of a [redacted] and [redacted] but that upon examination the [redacted] and were not present. Later in the shift, Resident #1 was sent to the emergency room (ER) for evaluation following a , as documented by Employee D, LPN. Photographic evidence obtained.	A 165		

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A 165	Continued From page 31 At 1:58 PM on Employee D, confirmed Resident #1 and hit her and was sent right after getting staples in the ER. She said Resident #1 had a dry couch that was getting worse, where she was having problems swallowing. She said she noticed the getting worse but thought the hospital would also notice the and treat it. Employee D explained that if Resident #1 couldn't swallow her pills it would be a major change and she would need to go to the hospital to be treated. She also stated it sometimes takes 2 to 3 days to receive an order after faxing the request to the physician. She would follow up the next day if the request hasn't be filled yet, and she would call if that was still unsuccessful. A facility Medication Tech, Employee E, stated at 2:49 PM on that she recalled Resident #1 experiencing difficulty swallowing pills whole, as was her norm, prior to her discharge. She stated she reported it to a nurse. A nurse's note documented on at 8:09 AM reported the resident's aide called the nurse because Resident #1 informed her "something wasn't right." When Employee B (LPN) entered the apartment the resident was trying to talk but was hard to understand, having difficulty swallowing, and her looks short. The breakfast tray was untouched. The med tech informed the nurse resident was unable to take her medications today or yesterday. She was sent to the hospital. Photographic evidence obtained. The endodontist documented on that Resident #1's treatment was discussed with her son. It noted the facility "failed to fill the script on . Only the	A 165		

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A 165	Continued From page 32 rinse script was filled." Photographic evidence was obtained. An interview was conducted with the Administrator on . . . . . at 3:47 PM . She confirmed that as of the time of the interview, she had not filed an adverse event for this event. She stated she was waiting for documents she requested from the endodontist, which she requested "last week", the third week of , , over a month since the resident's . . . . , - was ordered but not filled on , and the resident being sent to the hospital on . . . . . . On . . . . . at 10:10 AM, the endodontist's office manager confirmed the prescriptions and follow up , , details were given to the aide following Resident #1's , , on . . . . . . On . . . . . , the Administrator emailed a copy of an adverse incident that was filed, but it did not include an analysis of the situation or corrective action summary. Photographic evidence was obtained. Class III	A 165		