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
	AL11968563	A. BUILDING: _____ B. WING _____	09/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING BREEZE ASSISTED LIVING FACILITY	5940 NW 19TH COURT LAUDERHILL, FL 33313

(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 Licensure complaint survey, #2020011098, was conducted on [redacted] at Morning Breeze Assisted Living Facility. The facility had deficiencies at the time of the survey.	A 000		
A 010 SS=D	429.26( ) 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 must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, 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. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the	A 010		

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A 010	Continued From page 1 resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care. (d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to: a. Move, turn, or reposition without total physical assistance; b. Transfer to a chair or wheelchair without total physical assistance; or c. Sit safely in a chair or wheelchair without personal assistance or a physical . . . . 2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days. 3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days. (2). 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. (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial	A 010		

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A 010	Continued From page 2 examination for admission purposes may not have financial interests in the facility. 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 provider, the resident must be discharged from the facility. (c) A [illegible] ill resident who no longer meets the criteria for continued residency may continue	A 010		

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A 010	Continued From page 3 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: Based on observation, interview and record review, it was determined that the facility failed to reassess a resident for continued residency at the facility; after the resident demonstrated signficiant	A 010		

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A 010	Continued From page 4 violent behavioral changes, for 1 of 3 sampled residents reviewed (Resident # 1). As evidence of the facility failure to establish a documented plan to ensure appropriate supervision, care and services are provided to the resident based on the reassessment of Resident #1. The findings included: On between 09:00 AM - 04:00 PM, the following observations were made of Resident # 1. He was observed in the Dining Room. He was constantly pacing and forth. He was constantly talking to residents and Staff A. He was observed going and forth to his room, changing his jacket, and his masks. He was observed shouting at other residents. Staff A was constantly trying to redirect him, as he requested various foods and drinks. On at 10:25 AM, an interview was conducted with the facility Manager; a request was made to review the adverse reports regarding Resident #1. Review of Adverse incident reports provided by the facility for Resident #1 revealed the following. a) During the week starting Sunday 1st, , staff at the facility noticed Resident # 1 was getting upset when ever the other residents were speaking loud or having arguments among themselves. Resident # 1 always refer to the arguments of other residents as his argument and reacts very loud and angry and make up stories of things that may or may not be part of the discussion he overheard; yet he became so angry that he screams and curses, sometimes slamming doors and throwing items on the floor. His doctor was notified. Tele health visit was done and medications were readjusted. The change in	A 010		

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A 010	Continued From page 5	A 010		

medication did not appear to have great effect on Resident # 1; as the days went by he continued to have episodes of anger but his actions were not as disturbing as previous; he would complain that other residents did not like him and they are being mean to him and they want to beat him up. These accusations were false and staff tried to convince him that what he was saying was not true. He started to point out that he do not like Staff A, the employee working closely with him during the day. Staff A could not understand why he was saying he did not like her.

b) On the morning of . , like any other day everyone had breakfast and the atmosphere was peaceful until about 8:40 AM, Resident # 4, a resident at the facility passed by the table Resident # 1 was having breakfast. Suddenly Resident # 1 slammed his teacup on the table and pushed his plate away so that it went straight off the table onto the floor. Resident # 1 began screaming that he hate this place and he is leaving. Staff A tried to talk to him to calm him but it was of no use. Resident # 1 went to his room slamming the door and making rude remarks towards Staff A, since she was still trying to talk to him. Staff A left him and returned to kitchen to continue meal preparation. Lunch time approached. Lunch was served around 12:10 PM, Resident # 1 came out of his room and sat at the table but did not eat his food. He began making remarks about the food is not good and saying that Staff A has to leave because he do not like her. Resident # 3, a resident intervened at about 01:00 PM, telling Resident # 1 to stop making noise and to eat his food. Resident # 1 turned to Resident # 3 and in a loud screaming voice said "she is the problem" pointing to Staff A, the employee who was standing at the medicine cart about to distribute lunch medications. At

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A 010	Continued From page 6 01:08 PM, Resident # 1 got up from table and went to his room, kicking a table and a vent on the way to his room. At approximately 01: 20 PM, Resident # 1 came out of his room, he looked angry and he was holding a razor used for shaving in his and shouting " I am going to kill her and then kill myself" Resident # 1 kept repeating this. Staff A approached him to talk to him and he rushed towards her. Staff A moved out of his way and called the police (911). At 01:45 PM The police arrived and tried to calm Resident # 1, but he continued screaming and shouting that he is going to kill her and then kill himself. At 02:00 PM, when the police could not calm Resident # 1. They took him to the emergency room at the local hospital. On , a review of the record for Resident # 1 was conducted. It was revealed that there were 3 documents that indicated the hospital discharge summaries for Resident # 1 this year. Further review failed to indicate any progress notes and/or facility documentation dated for the following hospital admissions and discharges: . . . . . , ... and . The admission diagnosis: Staff stating he is being violent. He is refusing care and treatment. It was noted that Resident # 1 was admitted into the hospital on . . . . . and discharged on . The admission diagnosis was noted as the following; staff stating he is being violent, he is refusing care and treatment. Further review of the record revealed that there were not any updated Florida Health Assessments (AHCA 1823 forms), completed for the hospital admissions on and . . . . . . On . . . . . at 10:35 AM, an interview was conducted with Staff A. She stated that she was	A 010		

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A 010	Continued From page 7 the staff involved in the incident with Resident # 1. She says Resident # 1 was very upset because he couldn't get in touch with his Sister. She told him that she could not get in touch with his Sister either via phone. She says she only had one phone number for her. She says this started approximately 11:00 AM. He was very agitated and upset. He was calling her "stupid" She says she told him that she would try . . . later, She says around dinner at about 5:00 PM. She says when his sister, doesn't answer the phone he gets very upset. She says at about 6:30 PM, Resident # 1 comes out of the room with a broken piece of the razor blade. He threatened to kill her. She tried to calm him down. After that he said "no I'm gonna kill you". She asked one of the other residents (guy) to call 911. The police officers cane to the facility. He told the police officer that he wanted to kill her (Staff A). He told the police that he also wanted to kill himself. He was . . . . . and kept for 72 hours. She believes he went to one of the local hospitals. She says since he returned, he has been calmer because they changed his medication. She says now his Sister calls from time-to-time. She says his Sister would take him out for Pizza or Italian food. She says he cannot operate the phone on his own. She verified the findings in the adverse incident report. On . . . . . at 11:50 AM, an interview was conducted with Resident # 1. He says he doesn't like being there. He says the food is good. He stated he doesn't like the people who work there, but he likes Staff A. He says he also likes Staff B. He says he has a Sister and a Nephew. They come and see him. He talks to his sister on the phone. He says she takes him out to Italian restaurants. He says he has a roommate and he is jealous because he is cute. He says he's	A 010		

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A 010	Continued From page 8 gonna write a letter and tell them that he's leaving. He stated the police took him to the hospital. He says he doesn't remember what happened. On at 02:35 PM, an interview was conducted with the Manager and Staff A. They both agree that they were not aware of the circumstances that sent Resident # 1 to the hospital on . Staff A did indicate that Resident # 1 was returned to the facility after he had away, but she did not know the date. She says she believed that the this occurred prior to the Pandemic. A review of the Florida Health Assessment form (AHCA 1823 form) was conducted for Resident # 1. The AHCA 1823 form was dated for the initial admission. The diagnosis noted as , Fatty , and Rhabdomyolysis. or Behavioral status noted as alert and oriented x 4. Activities of Daily Living (ADL's) listed as independent with all of his ADL's. A second AHCA 1823 form dated was also located within the file. The diagnosis noted as the same as initial 1823 form . Physical or Sensory limitations is listed as physical ambulatory with steady gait, Sensory Within Normal Limits (WNL), or behavioral status is noted as alert and oriented x 3. Activities of Daily Living (ADL's) listed as independent with all of his ADL's. On at 02:35 PM, an interview was conducted with the Manager and Staff A. They indicated that they did not have any written notes and/or documentation (plan of care) to address the repeat violent behaviors of Resident # 1 to	A 010		

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A 010	Continued From page 9 prevent him from harm to himself or others. Class III	A 010		