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
	AL11965853	A. BUILDING: _____ B. WING _____	09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOSCH ALF, INC	3060 NW 19 TERRACE MIAMI, FL 33125

(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 Survey (#2020016030) was conducted at Bosch ALF on [redacted] and concluded on [redacted]. Deficiencies were identified at the time of the survey.	A 000		
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility must notify a licensed physician when a resident exhibits signs of [redacted] or [redacted] or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [redacted]. The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition. 59A-36.007 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community.	A 025		

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A 025	Continued From page 1 (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide appropriate care and services to meet the needs of two out 4 sampled residents (Resident # 1 and #2). Resident #1 ten days after being admitted into the facility with precautions and the facility waited three hours to call emergency services. Resident #2 was hospitalized with a , and of the orbital floor after a . Findings included: 1) Review of Resident #1's record revealed the resident was admitted into the facility on . A health assessment (AHCA Form 1823) completed on revealed the resident was diagnosed with , , dyslipidemia, , , and . Resident #1 had gait , precautions, and needed assistance in all Activities of Daily Living (ADL). Further review of Resident #1's record revealed no documentation of the precautions that were implemented.	A 025		

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A 025	Continued From page 2 Review of Resident #1's observation log revealed that on [redacted], the resident woke up and looked a little [redacted], lost her equilibrium, and hit herself with the closet in the upper part of the [redacted]. The log stated that 'emergency was called, and they checked Resident #1 and said everything was fine.' Observation on [redacted] at 8:46AM revealed Resident #1 with a purple skin discoloration around the right [redacted]. Examination of Resident #1 by Registered Nurse Consultant surveyor on [redacted] revealed no marks that corresponded with the described incident. Registered Nurse Consultant surveyor attempted to interview Resident #1 and revealed she was oriented just to her first name. During an interview on [redacted] at 10:14AM, Staff B stated "Resident #1 woke up in the middle of the night on [redacted] around 5AM and hit the closet door. Resident #1's roommate (Resident #3) informed me because I was still in bed. I then went to the room and helped Resident #1 up and checked on her. There was no injury except a [redacted] on the arm. I then helped Resident #1 to take a bath, take her medications, eat breakfast then continued regularly." Staff B further stated "I didn't immediately call 911 because she was fine and had no injuries. Around 8am, I called the administrator and she told me to call 911. Rescue came and did an [redacted], and provided [redacted] care for the [redacted]. They did not take the resident." During an interview on [redacted] at 3:33PM with the city of Miami emergency services, they stated [redacted] are not conducted on site.	A 025		

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A 025	Continued From page 3 During an interview on . . . . . at 12:39PM the administrator stated Resident #1's bed is parallel to her roommates' bed and the closet is on the left side of the wall, about 8 to 10 away from her bed. Review of Resident #1's record showed no documentation of follow up with a medical provider following the incident on . . . . . . During an interview with Resident #1's roommate (Resident #3) on at 10:35AM, Resident #3 stated she shared a room with Resident #1 and Resident #1 did not sleep at night. Resident #1 like to take off her clothes at night and walk naked around the facility. Resident #1 everywhere on the floor. Resident #3 further stated she "witnessed the first time Resident #1 but she did not witness the last night (. . . . .) because she finally asleep after being kept up the previous two nights by Resident #1. Around midnight last night, I heard a noise and saw an object on the floor. I got out of bed because I thought the object on the floor was Resident #1 and I was going to help her up. My socks got wet with and I wasn't able to help Resident #1 up because she was too heavy." During an interview on . . . . . at 10:38AM, Staff B stated "Resident #1 often got up at midnight to go to the bathroom and I was usually in bed between 10PM- 11PM. Resident #1 has never in the bathroom but she liked to urinate on the floor during the night. I reported this to the administrator. Resident #1 did not the previous night." During an interview on at 10:41AM, the	A 025		

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A 025	Continued From page 4 administrator stated "Resident #1 liked to take off her clothes off at night and walk around the facility nude. Resident #1 would urinate everywhere. Resident #1's doctor and family were aware of her change in behavior and they were notified of her ." Review of Resident #1's observation log dated revealed the resident had a condition of and on occasion she shows that she was unstable. It was hard for her to sleep and after 1pm she becomes disoriented. Further review of Resident #1's record revealed no documentation of her medical provider being notified of her inability to sleep or change in behavior after 1pm. During an interview with Resident #1's primary care physician on at 10:49AM, he stated the resident was only seen by him one time on via telehealth as she is a new patient. He further stated, the administrator called him today requesting for the resident to be seen due to a change in her behavior. Resident #1's primary care physician stated this is the first he has heard of any change in her behavior or condition. 2) Review of Resident #2's hospital records dated revealed the resident at home and had a to the right . Hospital records show the resident had an unwitnessed at the assisted living facility (ALF) and lost The resident was diagnosed with a , a of the orbital floor, at home, closed injury with brief loss of , and , Review of Resident #2's record revealed the	A 025		

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A 025	Continued From page 5 resident was admitted into the facility on . A health assessment (AHCA Form 1823) completed on revealed the resident was diagnosed with , , major , and . Resident #2 had precautions and needed assistance with ambulation, bathing, , eating, and toileting. Further review of Resident #2's record revealed no documentation of the precautions that were implemented. Review of Resident #2's observation log revealed that on , the resident hit herself on the top part of the and was transported to the hospital. There was no further information surrounding this incident in the resident's record. Observation on at 8:38AM revealed Resident #2 with a reddish/purplish skin discoloration around the right extending to half of the cheek under the . Examination of Resident #2 by Registered nursing surveyor on revealed no marks that corresponded with the described incident. Registered nursing consultant surveyor attempted to interview Resident #2 and revealed she was not oriented to time, person or place. During an interview on at 8:49AM, the administrator stated that "Resident #2 had a change in her behavior after 1 PM daily. The resident became disoriented and aggressive. The day of the incident, Resident #2 was in the dining room when she stood up from the chair suddenly and started to walk without using her walker. The resident hit the wall in the dining room." During an interview on at 9:35AM,	A 025		

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A 025	Continued From page 6 Administrator stated Resident #2's injury was last Saturday, . The administrator further stated the wrong date was documented on the progress notes. During an interview on at 10:26AM, Staff C stated "there was an incident with Resident #2 this weekend. Resident #2 is disoriented and doesn't follow instructions. Around 5:30PM on , we were seated in the living room, I just finished supervising her eat because she chokes and has swallowing issues sometimes when she eats. While I went to put away the dishes, the resident got up and tried to walk without using her walker and she hit the wall. Resident #2 was from the or forehead area, and I applied pressure while I called the administrator. The administrator then gave instructions to call 911 so I called them." During an interview on at 10:45AM, the administrator stated all staff were aware to call rescue first if there was an emergency "but, in this case, it was not an emergency, so staff called me first." The administrator further stated that a was an emergency depending on the situation, but it was more like an urgency. During an interview with Resident #2's medical provider on at 1:58PM, the clinical manager stated "the resident was seen at our facility yesterday, by an advanced registered nurse practitioner. In regard to her injury, we were told she . The resident has unsteady gait and frequent . The ALF stated she hit her during the . The resident was seen by a registered nurse at the ALF on and for a routine visit. The resident had a injury on from a possible and she had another on	A 025		

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A 025	Continued From page 7 which resulted in her going to the emergency room. The resident has precautions, so we had live education with the ALF informing them that the resident benefits from constant supervision." During an interview on at 11:30AM the administrator stated the precautions the facility implemented were to supervise residents more closely and help them with ambulation and transfer. Review of Resident #1's record revealed no documentation of the resident suffering an injury on . Class II	A 025		
A 027 SS=G	59A-36.007(3) FAC Resident Care - Arrangement for Health Care (3) ARRANGEMENT FOR HEALTH CARE. In order to facilitate resident access to health care as needed, the facility must: (a) Assist residents in making , , and remind residents about scheduled , , for medical, dental, nursing, or mental health services. (b) Provide transportation to needed medical, dental, nursing or mental health services, or arrange for transportation through family and friends, volunteers, taxi cabs, public buses, and agencies providing transportation. (c) The facility may not require residents to receive services from a , health care provider. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility	A 027		

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A 027	Continued From page 8 failed to assist residents with arrangements for health care services for two out of four sampled residents (Resident #1 and #2). Resident #1 in the middle of the night on and staff did not call emergency services until 3 hours later. There was no documentation that the primary care physician was notified or evaluated the resident after the . Resident #1 ran into a wall on and sustained a of the , and orbital floor and an , . Resident #1 also injured her on and there is no documentation of a primary care physician being notified after the incident. Findings included: 1) Review of Resident #1's record revealed the resident was admitted into the facility on . A health assessment (AHCA Form 1823) completed on revealed the resident was diagnosed with , , dyslipidemia, , , and . Resident #1 had gait , precautions, and needed assistance in all Activities of Daily Living (ADL). Further review of Resident #1's record revealed no documentation of the precautions that were implemented. Review of Resident #1's observation log revealed that on , the resident woke up and looked a little , lost her equilibrium, and hit herself with the closet in the upper part of the , . The emergency was called, and they checked Resident #1 and said everything was fine. Observation on at 8:46 AM revealed Resident #1 with a purple skin discoloration around the right , .	A 027		

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A 027	Continued From page 9 During an interview on at 10:14 AM, Staff B stated "Resident #1 woke up in the middle of the night on around 5 AM and hit the closet door. Resident #1's roommate (Resident #3) informed me because I was still in bed. I then went to the room and helped Resident #1 up and checked on her. There was no injury except a on the arm. I then helped Resident #1 to take a bath, take her medications, eat breakfast then continued regularly." Staff B further stated "I didn't immediately call 911 because she was fine and had no injuries. Around 8 am, I called the administrator and she told me to call 911. Rescue came and did an , and provided care for the . They did not take the resident." Review of Resident #1's record showed no documentation of follow up with a medical provider following the incident on . During an interview on at 12:39 PM, the administrator stated she contacted Resident #1's primary care physician and psychiatrist about the on . The administrator further stated she did not document her correspondence with the medical provider, and she will document everything from now one. During an interview with Resident #1's roommate (Resident #3) on at 10:35 AM, Resident #3 stated she shared a room with Resident #1 and Resident #1 did not sleep at night. Resident #1 like to take off her clothes at night and walk naked around the facility. Resident #1 everywhere on the floor. During an interview on at 10:38 AM, Staff B stated "Resident #1 often got up at	A 027		

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A 027	Continued From page 10 midnight to go to the bathroom and I was usually in bed between 10 PM- 11 PM. Resident #1 has never . . in the bathroom but she liked to urinate on the floor during the night. I reported this to the administrator. Resident #1 did not . the previous night." During an interview on at 10:41 AM, the administrator stated "Resident #1 liked to take off her clothes off at night and walk around the facility nude. Resident #1 would urinate everywhere. Resident #1's doctor and family were aware of her change in behavior and they were notified of her ." Review of Resident #1's observation log dated . . . . . revealed the resident had a condition of . . and on occasion she shows that she was unstable. It was hard for her to sleep and after 1 pm she becomes disoriented. Further review of Resident #1's record revealed no documentation of her medical provider being notified of her inability to sleep or change in behavior after 1 pm. During an interview with Resident #1's primary care physician on at 10:49 AM, he stated the resident was only seen by him one time on via telehealth as she is a new patient. He further stated, the administrator called him today requesting for the resident to be seen due to a change in her behavior. Resident #1's primary care physician stated this is the first he has heard of any change in her behavior or condition. During an interview with the administrator on at 12:39 PM she stated Resident #1 started having issues of not sleeping during the	A 027		

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A 027	Continued From page 11	A 027		

night and taking off her clothes 2 days after her admission. The administrator further stated she did not contact Resident #1's primary care physician until but she was in contact with Resident #1's psychiatrist.

Review of Resident #1's record revealed no documentation of the resident having a psychiatrist and no documentation of correspondence with a psychiatrist.

2) Review of Resident #2's hospital records dated revealed the resident at home and had a to the right . Hospital records show the resident had an unwitnessed at the assisted living facility (ALF) and lost . The resident was diagnosed with a , , a of the orbital floor, at home, closed injury with brief loss of , and .

Review of Resident #2's record revealed the resident was admitted into the facility on . A health assessment (AHCA Form 1823) completed on revealed the resident was diagnosed with , , , major , and . Resident #1 had precautions and needed assistance with ambulation, bathing, , eating, and toileting. Further review of Resident #1's record revealed no documentation of the precautions that were implemented.

Review of Resident #2's observation log revealed that on , the resident hit herself on the top part of the and was transported to the hospital. There was no further information surrounding this incident in the resident's record.

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A 027	Continued From page 12 During an interview on at 8:49 AM, the administrator stated that "Resident #2 had a change in her behavior after 1 PM daily. The resident became disoriented and aggressive. The day of the incident, Resident #2 was in the dining room when she stood up from the chair suddenly and started to walk without using her walker. The resident hit the wall in the dining room." Review of Resident #2's record revealed no documentation of follow up care with a medical provider about the residents change in behavior after 1 pm daily. During an interview with Resident #2's medical provider on at 1:58 PM, the clinical manager stated "the resident was seen at our facility yesterday, by an advanced registered nurse practitioner. In regard to her injury, we were told she . The resident has unsteady gait and frequent . The ALF stated she hit her during the . The resident was seen by a registered nurse at the ALF on and for a routine visit. The resident had a injury on from a possible and she had another on which resulted in her going to the emergency room. The resident has precautions, so we had live education with the ALF informing them that the resident benefits from constant supervision." During an interview on at 1:21 PM, the administrator stated Resident #2 hit her between her walker and she was in the following day so her medical provider ordered an to be completed at the facility. Review of Resident #2's record revealed no	A 027		

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A 027	Continued From page 13 documentation of the resident suffering an injury on or receiving any follow up care. During an interview on at 1:22 PM, the administrator stated there was no reason for not documenting the incident that occurred on or the , that was given at the facility. The administrator further stated it was too much to write. Class II	A 027		
A 030 SS=D	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,	A 030		

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	AL11965853	A. BUILDING: _____ B. WING _____	09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOSCH ALF, INC	3060 NW 19 TERRACE MIAMI, FL 33125

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A 030	Continued From page 14 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 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; 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	A 030		

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A 030	Continued From page 15 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 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	A 030		

Agency for Health Care Administration

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A 030	Continued From page 16 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 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	A 030		

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A 030	Continued From page 17 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 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	A 030		

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A 030	Continued From page 18 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; 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 observation and interview, the facility failed to follow current . . control standards related to COVID-19 and Florida Governor's emergency orders DEM Order 20-006, dated . . . . . The facility failed to ensure staff was using personal protective equipment properly	A 030		

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A 030	Continued From page 19 when caring for residents and placed residents and staff at risk for the COVID-19 . Findings included: 1) The COVID-19 is a transmissible ..., ..., ... that presents severe risk to persons who are aged, infirm, or suffer from co- ... including, but not limited to, system deficiency, , , , ..., and ... . See generally, Publications of the Centers for Control. On . , the Governor of the State of Florida issued Executive Order 20-51 designating a Public Health Emergency as a result of COVID-19 and its impact. Pursuant to that authority, emergency orders have been issued by the Florida Division of Emergency Management to implement the protections necessary to assure the health, safety, and well-being of Florida's citizenry, including those most to the effects of . Among those emergency orders was DEM Order 20-006, dated , ..., delineating minimum screening standards for persons entering identified residential facilities. The Centers for ... Control referred to Assisted Living Facility's high risk of COVID-19 spread to residents and stated: "Given their congregate nature and population served, assisted living facilities (ALFs) are at high risk of COVID-19 spreading and affecting their residents. If ... with SARS-CoV-2, the .. that causes COVID-19, assisted living residents-often older adults with underlying medical conditions-are at increased risk of serious illness."	A 030		

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A 030	Continued From page 20 Observation on . . . . . at 8:36 AM revealed Staff C (caregiver) assisting Resident #2 with ambulation to the dining area. Staff C was observed not wearing a mask and Resident #2 was observed not wearing a mask or . . . covering. Observation on at 8:46 AM revealed Staff C assisting Resident #1 out of a recliner in the living room. Staff C was observed not wearing a mask and Resident #1 was observed not wearing a mask or covering. Observation on at 8:47 AM revealed Staff C put on a blue procedural . . . mask. During an interview on . . . . . at 9:12 AM, the Administrator stated staff were to wear masks at all times. During an interview on . . . . . at 10:05 AM, the Administrator stated, "Staff and residents did not wear masks today because she was nervous with [surveyors] being here." During an interview on at 10:14 AM, Staff C stated she had been trained on COVID-19 control, but she did not wear a mask when providing care to residents alone in the facility because no one at the facility was positive for COVID-19. Observation on . . . . . at 10:34 AM revealed Resident #1 and Resident #2 seated in the living room on recliners directly next to each other. Residents were not abiding by social distancing rules and they were not wearing any masks. Review of facility's COVID-19 documents binder revealed the facility screening protocol was to	A 030		

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A 030	Continued From page 21 check temperature, disclose any symptoms, and answer questions about possible exposure to the Class III	A 030		
A 054 SS=D	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical , the facility must, pursuant to section 429.41, F.S., maintain a record of the prescribing	A 054		

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A 054	Continued From page 22 physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to keep an accurate Medication Observation Record (MOR) each time a resident received assistance with self-administration of medications for one out of 4 sampled residents (Resident #2). The facility failed to ensure that the residents' MOR included the [illegible], the name of the resident's health care provider and the health care provider's telephone number and chart for recording any missed dosages or refusals to take medication as prescribed for one out of 4 sampled residents (Resident #1). Findings included: 1. Review of the MOR for Resident #2 revealed the staff initialed for the evening medications on [illegible]. Resident #2 was scheduled to take [illegible] 0.5 MG tablet at 9 PM daily and Asper creme [illegible] Cream at 6:00 AM, 2:00 PM, and 10:00 PM daily. Review of hospital records for Resident #2 revealed the resident was admitted to a local hospital on [illegible] at 7:05 PM and discharged on [illegible] at 12:28 AM. During an interview on [illegible] at 1:18 PM, the Administrator stated Resident #2 was given her evening medication the following day when she returned from the hospital, so she signed it regularly on the MOR. 2. Review of Residents #1's MOR revealed it was missing the [illegible], the name of the resident's health care provider and the health care	A 054		

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A 054	Continued From page 23 provider's telephone number. During an interview on . . . . . at 1:23 PM, the Administrator stated Resident #1 transferred from another assisted living facility (ALF) and the family did not bring her MOR, they just brought the medication. Class III	A 054		
A 079 SS=D	59A-36.010(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum staff hours per week: Number of Residents, Day Care Participants, and Respite Care Residents — Staff Hours/Week 0-5 — 168 . . — 212 16-25 — 253 26-35 — 294 36-45 — 335 46-55 — 375 56-65 — 416 66-75 — 457 76-85 — 498 86-95 — 539 For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week. 2. Independent living residents, as referenced in subsection 59A-36.015(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for	A 079		

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A 079	Continued From page 24 purposes of computing minimum staff hours. 3. At least one staff member who has access to facility and resident records in case of an emergency must be in the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility. 4. In facilities with 17 or more residents, there must be at least one staff member awake at all hours of the day and night. 5. A staff member who has completed courses in First Aid and , , ( ) and holds a currently valid card documenting completion of such courses must be in the facility at all times. a. Documentation of attendance at First Aid or courses pursuant to subsection 59A-36.011(5), F.A.C., satisfies this requirement. b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and . 6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least , , must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or manager. 7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the	A 079		

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A 079	Continued From page 25 minimum staffing hours requirement. 8. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours, provided the administrator or manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule. 9. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted. (b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in rule 59A-36.007, F.A.C. (c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives. (d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision and care are not being provided to residents, resident care standards described in rule 59A-36.007, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility	A 079		

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A 079	Continued From page 26 administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire safety authority, the agency may require additional staff when the facility fails to meet the fire safety standards described in rule chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety requirements are being met. 1. When additional staff is required above the minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 59A-36.020, 59A-36.021 or 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on observation, record review and	A 079		

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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 079	Continued From page 27 interview, the facility failed to have an accurate staff schedule that showed current staff providing care and services to the residents. Findings included: Observation on . . . . . at 9:20 AM revealed a staff schedule posted for the period of through . . . . . The facility did not have a current schedule posted. Review of staff schedule for week to . . . . . revealed: -On . . . . . Staff A and Staff B were scheduled to work from 7 AM to 7 PM. Staff C was scheduled to work from 7 PM to 7 AM. -On Staff A was scheduled to work from 8 AM to 5 PM and staff C was scheduled to work from 7 PM to 7 AM. During an interview on at 10:11 AM, the Administrator stated Staff B worked the night of . During an interview on at 10:13 AM, the Administrator stated Staff C was working on at 5:30 PM when Resident #1 . During an interview on at 9:30 AM the Administrator acknowledged the posted staff schedule was not accurate. Class III	A 079		
A 162 SS=D	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include:	A 162		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965853	A. BUILDING: _____ B. WING _____	09/28/2020

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A 162	Continued From page 28 (a) Resident demographic data as follows: 1. Name, 2. [illegible], 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance [illegible], 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the health care provider and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 described in rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, [illegible], or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(e), F.A.C. (f) A [illegible] record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their [illegible] recorded semi-annually. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in rule 59A-36.006, F.A.C., if	A 162		

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A 162	Continued From page 29 such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to rule 59A-36.008, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in section 429.27, F.S. (l) If the resident is an [illegible] recipient, a copy of the Department of Children and Families form Alternate Care Certification for [illegible], CF-ES 1006, [illegible], which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the [illegible] of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is	A 162		

Agency for Health Care Administration

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A 162	Continued From page 30 a hospice patient as required in rule 59A-36.006, F.A.C. (o) The resident's [redacted], DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to the following at the discretion of the facility: 1. A log listing the names of residents participating in this arrangement, 2. The resident demographic data required in this paragraph, 3. The health assessment described in rule 59A-36.006, F.A.C., 4. The resident's contract described in rule 59A-36.018, F.A.C.; and, 5. A health care provider's order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to have an accurate health assessment for	A 162		

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A 162	Continued From page 31 two out of four sampled residents (#1 and #4). Findings included: Review of Resident #1's health assessment (AHCA Form 1823) dated revealed diagnoses and medical history of , , , dyslipidemia, , , , and . The resident had gait and precautions. The resident needed assistance in all ADL's. However, the health assessment also stated she was independent with all ADL's and able to administer medication without assistance. Observation on at 8:46 AM revealed Resident #1 with a purple skin discoloration around the right . During an interview on at 8:47 AM, the administrator stated that Resident #1 was in bed and tried to get out and lost her balance then hit her with the handle from the closet door. During an interview on at 9:18 AM the administrator stated Resident #1 needed assistance with bathing, , transferring in the morning and supervision with toileting. The administrator further stated Resident #1 was assisted with her medications. Review of Resident #4's health assessment (AHCA Form 1823) dated revealed diagnoses and medical history of , , , , , and . The resident had gait , poor insight, poor judgement, needed precautions and assistance with all ADL's. Further review of the health assessment showed she was independent with eating, needed supervision with ambulation, , grooming,	A 162		

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A 162	Continued From page 32 toileting, and transferring, and assistance with bathing. Class III	A 162		