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
	AL11910916	A. BUILDING: _____ B. WING _____	02/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EPWORTH VILLAGE RETIREMENT COM	5300 West 16 Avenue HIALEAH, FL 33012

(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 (2020003782) was conducted at Epworth Village Retirement Community on , , to , , . Deficiencies were identified at the time of the survey.	A 000		
A 025 SS=L	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or , . 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 must notify the resident ' s representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident ' s representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for 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	A 025		

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A 025	Continued From page 1 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. (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, record review and interview, the facility failed to provide adequate supervision as appropriate for each resident to ensure awareness of the general health, safety, physical and emotional well-being for 27 out of 40 sampled residents (Resident # 1, # 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 21, 22, 23, 24, 25, 26, 27, 28, and 38). Resident # 1 and # 2 were found on the streets after having eloped from the facility. Twenty-seven residents sustained a total of 40 . . between . . . . . and mid- , , which resulted in injuries such as . . bleeds, ... , , and . . . . . Resident # 6	A 025		

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A 025	Continued From page 2 sustained a . . . . . after falling and received no medical attention for at least 23 hours. Resident # 9 sustained a . . . . . after falling and received medical care four days after the . . . Resident # 5 was found foaming at the . . . . , with blue ˘ , , and breathing heavily after falling at the facility and received no medical attention until five hours later where the resident was found to have a , ... and needed surgery. Resident # 3, # 4, # 24, and # 28 all sustained . . . . . throughout their body and Resident # 8 sustained a hematoma to the after falling. Findings include: 1) Observation on at 7:59 AM showed Resident # 39 sitting in her wheelchair in the middle of the parking lot unsupervised and unattended. Observation on at 7:45 AM revealed upon entering the facility, a disoriented resident was left unsupervised in the front lobby. The resident could not remember what apartment number she lived in nor had a key to her apartment. The resident had asked a housekeeper nearby for help, and it was observed that the housekeeper ignored her and continued her day. A review of the facility's list of residents who were at risk of elopement risk or were not allowed to leave the facility revealed, Resident # 39 was not allowed to leave the facility because 'Resident is . . . . . ' Further observation on . . . . . at 8:15 AM revealed, Resident # 39 ˘ around the facility again lost and , asking where her room was located, and she stated, " there is	A 025		

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A 025	Continued From page 3 nobody there to help me" I do not know where I'm going." The resident wasn't wearing a mask. During an interview with Staff B, Director of Nursing on [redacted] at 8:41 AM, she stated, "[Resident #39] likes to be outside." A review of Resident #39's health assessment dated [redacted] showed medical diagnoses and a history of advanced multifactorial with behavioral manifestation, B ([redacted]) Thalassemia, abnormal hemoglobin, [redacted], class II [redacted], history of [redacted] with [redacted] left [redacted] hypertrophy, [redacted], and [redacted]. Resident #39 needed [redacted] precautions and assistance with ambulation, bathing, and [redacted]. The health assessment did not indicate Resident #39 was an elopement risk. 2) A review of the adverse incident showed on [redacted] at 12:35 PM, the resident's private duty aide approached Staff B, Director of Nursing and asked whether she saw Resident #1 walking around. Staff B replied no and placed a call to the nurse's station to alert staff to search for the resident. The staff immediately began searching the resident's apartment and commons areas inside as well outside of the facility. The facility then contacted Resident #1's daughter to notify her that her father was missing. Resident #1 had a SafetyNet however, it was found inside the resident's apartment. At 1 PM, police were called. At 2:25 PM, Resident #1's daughter called the facility and informed them thing to the at the resident was found by his stepson. At 2:50 PM, the resident was brought [redacted] to the facility by his daughter.	A 025		

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A 025	Continued From page 4 According to the SafetyNet Tracking Systems website, a SafetyNet is a GPS tracking bracelet used to locate residents. In an interview on at 12:44 PM, the administrator stated that "[Resident #1] likes to walk around. He sometimes walks alone depending on if the private duty is here. We usually call a Certified Nursing Assistant (CNA) to redirect him . . . to his room. They realized they couldn't find him. They immediately reported it to Staff B and me. We started looking around the facility. We got in our cars and started looking for him around the mall or supermarkets. Somebody at the plaza said that they saw a man who looked like he was looking for someone. We continued looking. We realized that he was nowhere to be found. We called the police. After that, we called the daughters, the daughter called saying that her brother or someone we're not familiar with, said that he found him in an area that was kind of far. He met with the daughter, and she brought him . A nursing assessment was done. Immediately, we put a picture in the front. Yes, he was an elopement risk. Rounds were increased to every half an hour to 45 minutes." On . . . . . at 1:48 PM, Staff B stated that Resident #1 was able to escape due to the security guard not recognizing Resident #1 as a resident that is not able to leave the facility. During an interview with Resident #1 on at 11:30 AM, he stated, "I did not remember the day I left the facility. I live far away. I don't know the address." In an interview on /2021at 12:12 PM, Resident #1's daughter stated that she was called by the facility and told her father was missing.	A 025		

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A 025	Continued From page 5	A 025		

She further stated, "As I was looking for my father, my brother called me multiple times, but I kept hanging up. The final time my brother said, 'don't hang up, I found [Resident #1].' My brother said that my dad was drenched with sweat leaning on a car in the corner of a parking lot, 3 miles away from the facility. I thought to myself, oh my gosh, what is he is doing there. My brother put him in his truck, and I met with him to take my dad from him. I brought him to the facility. The private duty aide was more for my mother than my father because she needed more care. The facility made her feel it was her fault that [Resident #1] off. When my father eloped, I suggested to the facility that there should be one way for cars to exit the property. Then I heard another person eloped, and they changed the way cars entered and exited the facility."

A review of Resident #1's health assessment dated showed medical diagnoses and a history of . . . . . The resident needed supervision with bathing. Resident #1 needed precautions and was identified as an elopement risk.

3) A review of the adverse incident report filed on . . . . . showed at 8:00 PM, Resident #2 was unable to be located at her apartment. The resident's neighbor stated that Resident #2 told her she was looking for her son. The staff immediately began to search inside and outside of the facility. The front gate security was contacted on whether he has seen the resident which he stated, no. At 9:40 PM, Resident #2's son contacted that facility to inform them that the resident was found outside the facility and was on her way . . . . . Resident #2's son was again contacted the facility at 9:58 PM to notify them

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A 025	Continued From page 6 that the resident arrived at the facility. A review of Resident # 2's health assessment dated showed medical diagnoses and a history of . . . . 's . . . . . , Major , , , ... , and . . . . . The resident needed assistance with bathing, ... , and self-care. The health assessment also indicated that Resident #2 had precautions and was an elopement risk. A review of the facility's elopement policies and procedures revealed an hourly monitoring log would be completed for residents at risk for elopement. A review of Resident #1 and #2's records showed no documentation of hourly monitoring before or after their elopements. During an interview with Staff B on at 12:44 PM, when asked whether there was documentation of the staff conducting the rounds, she stated, "no, we don't document the rounds." In an interview on at 1:48 PM, Staff B stated, "We have an exit door for the people that are walking. The latch for the gate door was not latching correctly, and she opened the door, and she left." In an interview with resident # 2's son on at 8:24 AM, he stated, "someone called me who saw my mother on the street after my mother gave them my number. I gave the guy the facility's address because he offered to drop her. I then called the facility I let them know my mom was found . . . . on the street."	A 025		

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A 025	Continued From page 7 4) During an interview on at 10:18 AM, the administrator stated, "in the last 3 months, there have been 10 . In the last 6 months there have been about double that amount." A review of the adverse incident database showed that the facility reported 21 for 21 residents in the last 6 months. A review of the facility's incident log revealed there were 46 for 27 residents for the months of and . A review of the facility incident log dated showed at 8:10 AM, Resident #1 notified Staff N, CNA, that he earlier. A was noted on the left arm, a scrape on the right , and a on the right upper . The was cleaned and covered. In an interview with Staff B on at 12:50 PM, she stated, "Resident #1 walks slowly, but because of his mental capacity, he will not use a walker." In an interview on at 1:17 PM, Staff N stated, she did not know anything about Resident #1 falling. When she was shown the incident log, Staff N then retracted her statement and stated, "yes, it is true Resident #1 did tell me he ." A review of a second facility incident log dated showed "at 5:35 PM received a call from security that [Resident #1] was walking towards the gate and ." The resident sustained a to the right . The was cleaned with and covered with a -aid. A review of a third facility incident log dated	A 025		

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A 025	Continued From page 8 . . . . . showed the resident was found lying on his on the floor. Some was noted on the right arm and a . . . on the right . The was cleaned with and covered with a . . .-aid. A review of the facility's prevention policy and procedures showed the facility "completes a standardized risk tool for residents upon admission within 24 hours. The facility would develop an initial risk care plan with interventions based on the residents' risk factors and assess further. The standardized Risk tool should be completed quarterly, at time of significant change and reviewed post- and updated if risk factors have changed." Record review of the residents who have at the facility showed no documentation of a risk tool completed at admission nor after any of the resident . . . 5) A review of the adverse incident reported filed on showed on at 11 AM Staff T, CNA notified the nurse that Resident #3 was on the floor. The resident sustained a . . . . to the forehead area. The resident's private duty aide stated, the "resident got up from the toilet, lost balance and forward hitting the floor." The resident was transferred to the hospital for further evaluation. On . . . . . at 11:45 AM, Staff T stated, "I don't know what happened. I didn't work that day." A review of Resident #3's hospital records dated . . . . . showed a 'History of Present Illness' that showed the patient with a history of , ... and . . . . who presented for a that caused a . . . . on her forehead	A 025		

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A 025	Continued From page 9 and frontal region. The patient had a repaired in the ER (emergency room) with stitches and staples. The patient's sister is also at the hospital with a after she was trying to help our patient up from the floor. A review of Resident #3's progress notes dated showed at "10 AM resident was sitting on the edge of the bed when her mattress slipped causing the resident to to the floor with mattress. No apparent injuries noted." 6) A review of the adverse incident filed on showed on at 11 AM, Staff T, CNA, notified the nurse that Resident #4 was on the bathroom floor. Upon arrival, the resident was observed to have a bump and some to the of the . The resident's private duty aide stated the resident (Resident #3) , and the resident went to assist her, she also , hitting of her on the floor. The resident was transferred to the hospital. In an interview on at 11:45, AM Staff T stated, "I never reported or saw anything about [Resident #3 or #4] ." A review of Resident #3's hospital records dated showed a 'History of Present Illness' that showed the patient with a past medical history of , who presented after an injury to her after a . The patient lives at a nursing home and her sister on the day of admission. Further review of hospital records showed that the CT(Computed) scan revealed that Resident #4 suffered a bifrontal	A 025		

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A 025	Continued From page 10 A review of Resident #4's progress notes dated showed at 1 PM, the resident complained of not feeling well. The resident was noted to have a to the left side of the /forehead. When asked if she , Resident #4 stated she the night prior. No other injuries were apparent. On at 7:57 AM, the resident's daughter called the nurse's station to inform staff that the resident on was the floor and needed help. Upon arrival, the resident was found lying on her right side. Resident #4's daughter stated the resident told her that she was before falling. A small was noted on the right side of the . The was cleaned, and the -aid was placed. No other were noted other than the one on the forehead Resident #4 sustained from the the night prior. In an interview on at 12:02 PM, Resident #4's daughter stated, "[Resident #3 and #4] would get lost in the facility, so we decided to put a camera in about seven months. I installed the camera into the room, and I watch them every day on the camera." 7) A review of the adverse incident filed on showed on at 1 PM, Resident #5 on her left side while ambulating outside of her apartment. The resident complained of in both sides of her , were ordered by Resident #5's physician, and the results showed a . At 6:48 PM, the resident was transferred to the hospital. A review of Resident #5's progress notes dated showed at 3:30 PM that the resident had completed. At 5 PM, Resident #5's doctor contacted the facility to have the resident transported to the hospital. The facility then	A 025		

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A 025	Continued From page 11	A 025		

contacted a non-emergency ambulance to transfer the resident to the hospital.

A review of the facility's incident report dated [redacted] showed at "6:45 PM [Resident #5] was found verbally unresponsive. The resident was in her bed, breathing heavy and foaming from the [redacted]. The resident was pale and her [redacted] blue. I immediately called 911 to have the resident transported to the hospital. Rescue arrived at 7 PM. Departing with the resident at 7:06 PM." (sic)

A review of Resident #5's hospital records dated [redacted] showed a 'History of Present Illness' that showed the patient was sent because of a left [redacted] injury but was observed with severe [redacted] distress. The resident was admitted to the [redacted].
Further review of the hospital records showed that Resident #5 was discharged from hospital care on [redacted].

A review of Resident #5's health assessment dated [redacted] showed medical diagnoses and a history of acute nondisplaced [redacted] radial [redacted], history of major [redacted], balance, gait [redacted], history of [redacted], and [redacted]. The resident needed supervision with [redacted], assistance with bathing, eating, self-care, and toileting. The health assessment also indicated that Resident #5 needed [redacted] precautions.

8) A review of the facility's incident log dated [redacted] showed at 1:56 AM, Resident # 6 pressed the call light notifying staff of assistance. Upon arrival, the resident was found lying on the floor of the bathroom. Staff observed Resident #6 with "his pants and adult briefs off with

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A 025	Continued From page 12 movement and on the floor." The resident denied any , and was assisted from the floor to the chair. A review of the adverse incident report dated showed on at 6:40 AM, Resident #6 . Upon arrival, the resident was observed sitting on the bathroom floor. The resident complained of and , in the right . On at 5:13 AM, Resident #6 was "very disoriented and unable to recall what he was doing." At 7 AM, the resident was transferred to the hospital for further evaluation. A review of progress notes dated at 9 PM, Resident #6 complained of and , in the right . The resident was given and " medication." On at 5:03 AM, Resident #6 complained of and , in the right . For ten minutes, staff observed that the resident was disoriented. The ambulance was called at 5:30 AM with an estimated arrival time of hours. The resident was then sent to the hospital. Review of Resident #6's hospital records dated showed a 'History of Present Illness' that showed the patient is coming from ALF. His symptoms began three days ago without any other associated symptoms. The patient was admitted with the diagnosis of a , , and , . During an interview on at 11:53 PM, Resident #6's daughter stated, "My dad because he had a when he got to the hospital, they realized he was getting and falling. When I noticed that he was falling multiple times, I agreed to send him to the hospital." She further stated, "They notified me	A 025		

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A 025	Continued From page 13 about the incident on [redacted], but they didn't tell me he [redacted]. They told me he tripped over his walker because he was going too fast." A review of resident # 6's health assessment showed medical diagnoses and a history of [redacted], unspecified sequelae of [redacted], Type 2, [redacted] with [redacted] deficiency, [redacted], and [redacted]. Resident # 6 needed Assistance with ambulation, bathing, [redacted], self-care, toileting, and transferring. 9) A review of the adverse incident report filed on [redacted] showed on [redacted] at 12:45 PM, Resident #7 was found by CNA on the shower floor inside his apartment. The resident was observed with a bump on the left side of his [redacted]. The resident complained of a [redacted]. At 1:30 PM, Resident #7 was transferred to the hospital." Review of Resident #7's hospital records dated [redacted] showed a 'History of Present Illness' that showed ' [redacted] male history of previous [redacted], A. fib ([redacted]) presents to the ED (emergency department) after a [redacted] from the assisted living facility. The patient had an unwitnessed [redacted], complaining of left [redacted] and [redacted]. The patient is a poor historian.' A review of Resident #7's health assessment dated [redacted] showed medical diagnoses and a history of a [redacted] with [redacted], and [redacted]. The resident needed supervision with toileting, transferring, and assistance with ambulation, bathing, [redacted], and grooming. The	A 025		

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A 025	Continued From page 14 assessment also indicated that Resident #7 had precautions. 10) A review of Resident #8's progress notes dated showed that the resident was observed lying on the floor in her apartment down by staff. A review of the adverse incident report filed on showed on at 10:15 AM, Resident #8 was observed on the floor of her apartment. Upon assessment by the nurse, the resident was observed to have a hematoma on the right side of her and complained of , when touched. The resident was transferred to the emergency room for further evaluation. A review of Resident #8's hospital records dated showed 'History of Present Illness' that showed , (year old) female presents s/p (stats post) mechanical trip and , which occurred 1 hour PTA (prior to arrival). The patient states she now has lower , left , to the of her . Additional review of the hospital records showed that Resident #9 was found to have a large right , hematoma. On at 2:11 PM, Resident #8's daughter stated, "my mother has only been at the facility for a month. This was her first time falling at the facility, but she has before. She requires a lot of attention." A review of Resident # 8's health assessment dated showed medical diagnoses and history of , , , and , stage 5. The resident needed supervision with ambulation,	A 025		

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A 025	Continued From page 15 bathing, [illegible], self-care, toileting, and transferring. 11) A review of Resident #9's progress notes dated [illegible] showed that at 7 AM, Resident #9's wife called the nurses station stating that her husband was on the floor. Upon arrival, the resident was found lying on his [illegible] near the bathroom door. A small [illegible] was noted on the right side of Resident #9's [illegible]. A review of the adverse incident report dated [illegible] showed at [illegible] at 5:30 PM, Resident#9's called the nurse's station to notify the nurse that the resident was on the floor. Upon arrival, the resident was found lying on his next to his bed. The resident sustained a [illegible] and [illegible] to his left side. A review of progress notes dated showed at 6 AM, Resident #9 complained of soreness to the [illegible] area and was given an ice bag to apply to the area. At 6 PM, Resident #9 complained of , in the left side of the , where [illegible] was located. On [illegible] at 8:42 AM, the facility notified Resident # 9's physician of the [illegible] and , complaint. On [illegible] at 7 AM, Resident # 9 complained of , again. At 10 AM, Resident # 9 complained of , again, and his physician ordered an [illegible], of the [illegible] and [illegible]. At 1:40 PM, [illegible], results showed a [illegible] of the [illegible], and the physician ordered for Resident #9 to be transferred to the hospital. The facility contacted a non-emergent ambulance to pick up the resident, and their estimated time of arrival was 4 hours. At 2:10 PM, Resident # 9's daughter refused for her father to be transported to the hospital, and the non-emergent ambulance was canceled. On [illegible] at 4:20 PM, Resident # 9 was found [illegible], clammy, pale, and	A 025		

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A 025	Continued From page 16 "unresponsive" with [illegible] bent down and [illegible] closed. 911 was called. Fire rescue checked [illegible] and was [illegible] (low [illegible]) and sent to the hospital. A review of Resident # 9's hospital records dated [illegible] showed a Chief Complaint '[illegible]' and a 'History of Present Illness' that showed '88 y/o (year old) with h/o (history of) witness syncopal episode in ALF (Assisted Living Facility). The patient became unwell, fainted, and had four episodes of non-bloody [illegible]. Upon the arrival of paramedics, he was [illegible] and responded well to a fluid bolus. In ED (emergency department), patient c/o (complained of) left [illegible] and [illegible]. The patient had an h/o (history of) [illegible] one week ago. Additional review of Resident # 9's hospital records revealed a statement from Resident # 9's daughter that had told the hospital "her father has had a history of [illegible] after his ([illegible]) in [illegible] ([illegible]) 2020, after which he sustained left-sided [illegible], and hematoma". In an interview with Resident #9's daughter on [illegible] at 1:57 PM, she stated, "he periodically. He has a weak right [illegible], so every month, he has a [illegible]." When asked if anything was implemented after the multiple [illegible], she stated, "no, there is nothing more they can do." A review of Resident # 9's health assessment dated [illegible] showed medical diagnoses and history of [illegible] stones, [illegible] prostatic hyperplasia, [illegible] and collapse, [illegible], and [illegible]. The	A 025		

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A 025	Continued From page 17 resident needed assistance with ambulation, bathing, , eating, self - care (grooming), toileting, and transferring. The health assessment indicated that the resident had no precautions. Further review of Resident #9's records showed no documentation of an updated health assessment after Resident #9's . 12) A review of Resident #10's progress notes dated showed at 2:30 PM, the resident onto the floor while transferring from toilet to wheelchair in the bathroom with CNA assistance. The CNA pulled the call light, and upon arrival, the resident was observed sitting on bathroom floor between the wall and left side of the toilet. The resident denied hitting and stated she had , in her right . A review of Resident #10's health assessment dated showed medical diagnoses and a history of Major , & collapse, , and . The resident needed assistance with ambulation, bathing, , eating, self-care, toileting, and transferring. The health assessment also indicated that Resident #10 needed precautions. 13) A review of Resident #11's progress notes dated showed at 3:25 PM, the resident was found sitting on the floor with his against some books, out towards the door's opening with his underwear around the ankles. The staff noted that the resident had "no apparent injuries." A review of Resident #11's health assessment dated showed medical diagnoses and a history of ,	A 025		

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A 025	Continued From page 18 's, Major , frequent , and physical deconditioning. The resident needed supervision with eating and toileting and assistance with ambulation, bathing, self-care, and transferring. The health assessment also indicated that Resident #11 had precautions. 14) A review of the facility's incident log dated showed at 11:30 AM, Resident # 12 slipped and onto the floor. The resident was noted to have a purplish bump/ to the left / area. Staff placed an ice pack to the resident's left / and encouraged her to keep the ice pack on for 15 minutes to keep / down." A review of Resident #12's health assessment dated showed medical diagnoses and a history of left total , replacement, , and . The resident needed supervision with ambulation, transferring and needed assistance with bathing and . The health assessment also indicated that Resident #12 had safety precautions. 15) A review of the facility's incident log dated showed at 8:15 PM, Resident # 13 was found on the floor in the hallway next to the bedroom by CNA. The resident denied any , and staff noted that the resident sustained no injuries. Resident #13 was then assisted up and used the walker to ambulate to the bedroom. A review of Resident #13's health assessment dated showed medical diagnoses and a history of , and gait disturbance. The resident	A 025		

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A 025	Continued From page 19 needed supervision with ambulation, bathing, self-care, toileting, and transferring. 16) A review of the facility's incident log dated showed at 7:20 PM, Resident #14 was found on the floor. Staff observed the resident sitting at the of the bed with his briefs "halfway up." Resident #14 denied hitting his but complained of , in his . A review a second facility incident log dated showed at 9 PM; Resident #14 used his call light to notify staff he needed assistance. Upon arrival, the resident was found lying on his by the side of his bed with "brief stuck on the bedrail." The resident had to both of his . A review of a third facility incident log dated showed at 5:30 PM; Resident #14 was found sitting on the floor of his bedroom. A was noted to the resident's left upper arm. Review of Resident #14's hospital records dated showed a 'History of Present Illness' that showed the patient was sent to his primary care, where he was expressing , and was found to have a . A review of Resident #14's health assessment dated showed medical diagnoses and a history of generalized , major , , hypertensive D deficiency, , and history of . The resident needed	A 025		

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A 025	Continued From page 20 supervision with ambulation, eating, toileting, transferring, and assistance with bathing, [illegible], and self-care. The health assessment also indicated that Resident #14 needed precautions. 17) A review of the facility's incident log dated [illegible] showed at 10:15 AM, Resident #15 was found on the floor by staff. No apparent injuries were noted. A review of Resident #15's health assessment dated [illegible] showed medical diagnoses and a history of [illegible]. The resident needed assistance with ambulation, bathing, [illegible], self-care, toileting, and transferring. The health assessment also indicated that Resident #15 needed precautions. 18) A review of Resident #16 progress notes dated [illegible] showed at 7:18 AM, staff was notified that the resident was on the floor. Upon arrival, the resident was observed next to his bed on the floor. No apparent injuries were noted. A review of Resident #16's health assessment dated [illegible] showed medical diagnoses and a history of [illegible], Aphasia, gait disturbance, [illegible], skin [illegible], and [illegible]. The resident needed assistance with ambulation, bathing, [illegible], eating, self-care toileting, and transferring. 19) A review of Resident #17's progress notes dated [illegible] showed at 11:45 AM, the resident was found on the bathroom floor sitting in front of the toilet. The resident was assisted up	A 025		

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A 025	Continued From page 21 to a standing position and had no complaint of . A review of Resident #17's health assessment dated showed medical diagnoses and a history of of , hyperlipemia, obese class I, , a due to , and moderate . The resident needed supervision with bathing. The assessment also indicated that Resident # 17 needed precautions. 20) A review of Resident #18's progress notes dated showed at 2:47 AM, the resident was found lying supine in front of his recliner. Resident #18 complained of , in the . The staff gave the resident and assisted him to bed. A review of Resident #18's health assessment dated showed medical diagnoses and a history of , in , and end of stage . The resident needed assistance with ambulation, bathing, , self-care, toileting, and transferring. A review of the facility's incident log dated showed at 9:33 PM, "while on the floor CNA notified nurse by phone that resident was found on the floor. Upon arrival, the resident was standing by the table because she got up by herself by grabbing the chair. The resident stated, 'I . I ' couldn't recall how she . No apparent injury. Denied , , denied hitting the ." 21) A review of Resident #19's health	A 025		

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A 025	Continued From page 22	A 025		

assessment dated showed medical diagnoses and a history of 's , memory loss, , history of , fasting , , and . The resident needed assistance with ambulation, bathing, , and transferring.

22) A review of the facility's incident log dated showed at 9:35 PM, Resident #20 notified the nurse she had after losing balance trying to turn on her apartment light. The resident denied any and had no apparent injuries.

A review of a second facility incident log dated showed at 8:15 AM, Resident #20 notified the nurse that she had the night prior. The resident complained of in the and behind the .

A review of Resident #20's health assessment dated showed medical diagnoses and a history of Fraction, of Bells' , and . The resident needed supervision in ambulation, toileting, transferring, and assistance bathing, , and self-care. The health assessment also indicated that Resident #20 needed safety precautions.

23) A review of the facility's incident log dated showed at 11:15 PM, Resident #21 was found on the floor. No injuries were noted."

A review of Resident #21's progress notes dated at 1:45 PM, "roommate called the

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A 025	Continued From page 23 station to notify nurse that resident was on the floor. Upon arrival, the resident was sitting on the floor by the table. No sign of apparent injury was noted, denied , . Denied hitting the ." A review of Resident #21's health assessment dated showed medical diagnoses and a history of , , , Atherosclerotic with , and Moderate Insufficiency. The resident needed supervision with self-care, toileting, and transferring and needed assistance ambulation, bathing, and . The health assessment also indicated that Resident # 21 needed safety precautions. 24) A review of the facility's incident report dated showed at "4:10 PM notified by Staff P, housekeeper that [Resident #22] was on the floor in hallway by timeclock. The resident noted sitting on the floor with up against the automatic door. Resident shoes were noted to be off, and the resident was holding their right . The resident stated, 'the door didn't open, so I tried to open and .' In an interview on at 12:24 PM, Staff P stated, "I have never found anyone on the floor in all the time I have worked at the facility. If there is a report with my name, it's not true because I am the only housekeeper with this name working at the facility." Further review of a second incident log dated showed at "7:35 PM received notification from Staff U, CNA about [Resident #22] being on the floor. Upon arrival, the resident was sitting on the floor by her dining table and chairs. The resident was asked how she and	A 025		

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A 025	Continued From page 24 stated, 'I was there doing my hair when I lost balance and hit my left side at the edge of the wall and .' The resident complained of , to the left of the . Slight redness noted." In an interview on at 12:10 PM, Staff U stated she didn't know anything about the . A review of Resident # 22's health assessment dated medical diagnoses and a history of , diverticulosis, solitary , nodule, and abnormal . The resident needed supervision with ambulation, and assistance with bathing, , grooming, toileting, and transferring. The health assessment also indicated that Resident #22 needed precautions. 25) A review of the facility's incident log dated showed that the facility was notified by Resident #23's son that his mother was on the floor. The resident complained of , in the right , and had difficulty walking. A review of a second incident log dated showed Resident # 23 went to the nurse's station reporting that she was sleeping in bed and rolled off the bed onto the floor. A and bump were noted to the left lower arm, and a bump was noted to the of the . A review of Resident # 23's health assessment dated showed medical diagnoses and a history of mild type II, , and . The resident needed supervision with ambulation, bathing, grooming, toileting, and transferring. The health assessment	A 025		

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A 025	Continued From page 25 also indicated that Resident #23 needed precautions. In an interview on at 11:37 AM, Resident #23's son stated, "my mom called me and told me she , and her , hurt, so I notified the facility." 26) A review of the facility's incident log dated showed at "3:57 PM received call from CNA that [Resident #24] was on the floor. No signs of injury noted." A review of Resident #24's health assessment dated showed medical diagnoses and a history of , , , , , gait disturbance, , , history of lower , , , , and . The resident needed assistance with bathing, and supervision with ambulation, , eating, grooming, toileting, and transferring. The assessment also indicated that Resident #24 had safety precautions. A review of the facility's incident log dated showed Resident #24 was found on the floor lying close to the bed with his between the bed rails. Redness was observed behind the resident's and between the and . 27) A review of Resident # 25's health assessment dated showed medical diagnoses and a history of , , Prostatic Hyperplasia, D deficiency, , , and polycythemia. The resident needed supervision with eating and assistance with ambulation, bathing, , self-care,	A 025		

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A 025	Continued From page 26 toileting, and transferring. The health assessment also indicated that the resident needed safety precautions. 28) A review of the facility's incident report dated showed that Resident #26 roommate notified the nurse's station that the resident was on the floor. Upon arrival, she was found sitting on the floor near the dining room table and chair. No apparent injuries were noted. A review of Resident #26's health assessment dated showed medical diagnoses and a history of , sleep , and status post Permanent . The health assessment also indicated that Resident # 26 needed safety precautions. 29) A review of Resident #27's progress notes dated showed "received a call from staff that resident was on the floor. Upon arrival to the room, the resident was sitting on the living room floor. Some was observed to the left , noted to the area, small. Redness was noted to the top of the left cleaned with normal , triple applied and covered area with a gaze." A review of Resident # 27's health assessment dated showed medical diagnoses and a history of , type 2 with , stress , poor gait, and balance, history of lens replacement. The resident needed supervision with bathing, , grooming, and toileting. The assessment also indicated that Resident #27 had precautions.	A 025		

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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 025	Continued From page 27 30) A review of Resident #37's progress notes dated [illegible] showed "was notified by staff that resident was on the floor. Upon assessment, the resident was found sitting on the [illegible] in the bathroom. No injuries were apparent." A review of Resident # 37's health assessment dated [illegible] showed medical diagnoses and a history of [illegible] of [illegible] with [illegible] and [illegible] disc [illegible] of multiple sites, [illegible] lower [illegible] D deficiency, major [illegible], severe [illegible] with history of [illegible], frequent [illegible], and [illegible]. The resident needed assistance with bathing and [illegible]. A review of the facility's [illegible] prevention policies and procedures showed the facility 'completes a standardized [illegible] risk tool for residents upon admission with 24 hours. The facility would develop initial [illegible] risk care plan interventions based on residents' risk factors and assess further. The [illegible] risk tool should be reviewed post- [illegible] and updated if risk factors have changed.' Record review of the residents who have [illegible] at the facility showed no documentation of a [illegible] risk tool completed at admission nor after any of the resident [illegible]. In an interview with the Director of Nursing (DON) on [illegible] at 1:30 PM, she stated, "We conduct frequent rounds on residents who [illegible] a lot, a lot is considered more than 3 [illegible] in a	A 025		

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	AL11910916	A. BUILDING: _____ B. WING _____	02/15/2021

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A 025	Continued From page 28 month. We check on them every hours." In an interview on at 1:31 PM, the administrator stated that once a resident has at the facility staff increase the rounds to every hour. She also stated that the residents who have multiple times, staff create an individualized plan of care to prevent further occurrences. A record review of the residents who have showed no documentation of a plan of care or any investigation into the resident other than asking the resident how they . On at 1:30 PM, Staff B stated, "We have a lot of residents with precautions, we work in an elderly community with a lot of elderly, and the elderly a lot, that is part of their aging process". Class I	A 025		
A 030 SS=G	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	A 030		

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A 030	Continued From page 29 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 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	A 030		

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A 030	Continued From page 30 sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. (g) In addition to the requirements of section 429.41(1)(k), F.S., the use of physical by a facility on a resident must be reviewed by the resident's physician annually. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance, is not considered a physical . . . . 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges 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	A 030		

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A 030	Continued From page 31 personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at 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	A 030		

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A 030	Continued From page 32 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 given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. 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 [illegible], 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.	A 030		

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A 030	Continued From page 33 (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; 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	A 030		

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A 030	Continued From page 34 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, interview and record review, the facility failed to provide a safe and decent living environment to the residents. Staff did not follow control, sanitation, or universal precautions procedures when providing medications to residents. The facility also failed to keep resident's information confidential. Findings included: 1) Observation on at 8:15 AM revealed Staff J providing assistance with self administration of medication on the first floor of building two. On at 8:16 AM Staff J was observed dropping the medication on the medication cart, then touching the medication with her bare and placing it in a cup for the resident's consumption. During an interview on at 2:10 PM, Staff D stated "If a medication on the cart, we are supposed to throw it away. We are supposed to wear gloves when giving out medication. I know I wear them." 2) Review of the facility's 24-hour nursing shift report dated during the 11 PM-7 AM	A 030		

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A 030	Continued From page 35 shift revealed " : Resident's room bathroom really dirty, staff reported it in change of shift. We have nothing to clean with. Please report to housekeeping. At 11 PM on floor was very dry, pictures on phone." During an interview on at 12:47 PM, the administrator stated no one has ever run out of cleaning supplies. We have plenty of cleaning supplies. If someone did run out, they would tell me or their direct supervisor Staff F." During an interview on at 12:48 PM, Staff F, stated that "Housekeeping reports to me and nursing depending on the situation will report to me. No one has complained of running out of cleaning supplies. If they had they would come to me. The latest shift for housekeeping ends at 6 pm, there is no housekeeping at night. If there is movement on the floor the CNA should pick it up and discard it and when housekeeping arrives in the morning then they will clean it. CNA have access to the closet where cleaning supplies and linen are in. If something happened, they would report it to me in the morning. During further interview on at 12:52 PM, the administrator stated "I don't have the slightest clue what happened that day, I can't tell. But the staff does have access to cleaning supplies. We would normally get a report the next morning at the nursing station, but I did not receive a report for this incident." During further interview on at 1:16 PM, Staff F stated I was off work the day following this incident, my notes for the day of the incident are just a scribble written down." During an interview on at 1:01 PM Staff	A 030		

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A 030	Continued From page 36 E stated "We don't have access to the supplies. The supplies are in another building. You would have to call the director of maintenance to ask him where the room is. The nursing staff don't use the cleaning supplies." 3) Observation on . . . . . at 8:20 AM revealed an unlocked nursing station in building 5. Inside the nursing station, observed an unattended resident records for all building 5 residents. Review of the facility's Resident safety and dignity policy showed "Residents have the right to be treated with consideration, respect, and with due recognition of personal dignity, individuality, and the need for privacy." During an interview on at 2:18 PM, the DON stated, "The resident's records should not be left unattended that is against HIPAA." Class II	A 030		
A 032 SS=E	59A-36.007(8) FAC Resident Care - Elopement Standards 59A-36.007 (8) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A	A 032		

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A 032	Continued From page 37 resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case	A 032		

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A 032	Continued From page 38 manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to sections 429.41(1)(a)3. and 429.41(1)(i), F.S. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to follow its policies and procedures regarding elopement when two out of 40 sampled residents eloped from the facility (Resident #1, #2). Resident # 1 and # 2 were found on the streets after having eloped from the facility. Findings include: A review of the facility's records revealed a binder located in the front gate security office that had at least 42 pictures of residents who are considered an elopement risk or are not allowed to leave the facility without their legal guardian ' s permission. During an interview on ..... at 12:45 pm, the Administrator stated that only 13 residents are considered an elopement risk. A review of the adverse incident showed at 12:35 PM, the resident's private duty aide approached Staff B and asked whether she saw Resident #1 walking around. Staff B replied no and placed a call to the nurse's station to alert staff to search for the resident. The staff immediately began searching the resident's apartment and commons areas inside as well	A 032		

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A 032	Continued From page 39 outside of the facility. The facility then contacted Resident #1's daughter to notify her that her father was missing. Resident #1 had a safety net; however, it was found inside the resident ' s apartment. At 1 PM, police were called. At 2:25 PM, Resident #1's daughter called the facility and informed them that the resident was found by his stepson. At 2:50 PM, the resident was brought . . . to the facility by his daughter. In an interview on . . . . . at 12:12 PM, Resident #1's daughter stated that she was called by the facility and told her father was missing. She further stated her father was found by her brother in a parking lot 3 miles away from the facility. She met with her brother to pick up her father and returned him to the facility. On . . . . . at 1:48 PM, Staff B stated that Resident #1 was able to escape due to the security guard not recognizing Resident #1 as a resident that is not able to leave the facility. A review of Resident #1's health assessment dated . . . . . showed medical diagnoses and a history of . The resident needed supervision with bathing. Resident #1 needed precautions and was identified as an elopement risk. A review of the adverse incident reported filed on . . . showed at 8:00 PM, Resident #2 was unable to be located at her apartment. The resident ' s neighbor stated that Resident #2 told her she was looking for her son. The staff immediately began to search inside and outside of the facility. The front gate security was contacted on whether he has seen the resident which he stated no. At 9:40 PM, Resident #2's son contacted that facility to inform them that the	A 032		

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A 032	Continued From page 40 resident was found outside the facility and was on her way . The resident was again contacted at 9:58 PM to notify them that the resident arrived at the facility. In an interview with resident # 2's son on at 8:24 AM, he stated, "someone called me who saw my mother on the street after my mother gave them my number. I gave the guy the facility's address because he offered to drop her. I then called the facility to let them know my mom was found on the street." In an interview on at 1:48 PM, Staff B stated that "We have an exit door for the people that are walking. The latch for the gate door was not latching correctly, and she opened the door, and she left." A review of Resident # 2's health assessment dated showed medical diagnoses and a history of 's , Major , and . The resident needed assistance with bathing, , and self-care. The health assessment also indicated that Resident #2 had precautions and was an elopement risk. A review of the facility's elopement policies and procedures revealed a ' Resident Monitoring Log ' for residents who are at risk of elopement. The document showed, "Every hour, Nurse or CNA, must initial verify resident location." A review of Resident #1 and #2's records showed no documentation of hourly monitoring before or after their elopements. A review of resident records for those considered	A 032		

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A 032	Continued From page 41 an elopement risk revealed no documentation of a Resident Monitoring Log. In an interview on at 1:31 PM, when asked about the elopements, the administrator stated that the security guards had failed to recognize that the residents were at risk of elopement and that they should not leave the grounds. In an interview on at 10:40 AM, the security guard on duty stated that he received a binder with the photo and names of the residents who are not allowed to leave the facility without permission or company. He was told to call the receptionist when he identified any of those residents attempting to leave. In an interview on at 12:44 PM, when asked if the security guards were retrained on elopement policies and procedures, the administrator stated that the security guards are staff from the health center on the same property and not a part of the facility's staff. The facility did not have documentation of training in elopement procedures for the security guards. Class III	A 032		
A 052 SS=D	429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, including an syringe that is prefilled with the proper dosage by a pharmacist and an that is	A 052		

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A 052	Continued From page 42	A 052		

prefilled by the manufacturer, from where it is stored, and bringing it to the resident.
(b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident ' s medications or dosages change.
(c) Placing an oral dosage in the resident ' s or placing the dosage in another container and helping the resident by lifting the container to his or her .
(d) Applying , medications.
(e) Returning the medication container to proper storage.
(f) Keeping a record of when a resident receives assistance with self-administration under this section.
(g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the .
(h) Using a to perform level checks.
(i) Assisting with putting on and taking off stockings.
(j) Assisting with applying and removing an but not with titrating the prescribed settings.
(k) Assisting with the use of a continuous positive airway pressure device but not with titrating the

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A 052	Continued From page 43 prescribed setting of the device. (l) Assisting with measuring vital signs. (m) Assisting with [illegible] bags. (4) Assistance with self-administration does not include: (a) Mixing, [illegible], converting, or [illegible] medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a [illegible] of the body. (d) Administration of [illegible] preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with [illegible], or [illegible] preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008	A 052		

Agency for Health Care Administration

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A 052	Continued From page 44 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be , or older, trained to assist with self administered medication pursuant to the training requirements of rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in section 429.256, F.S. and this rule. (b) In addition to the specifications of section 429.256(3), F.S., assistance with self-administration of medication includes, in the presence of the resident, reading the medication label aloud and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the	A 052		

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A 052	Continued From page 45 resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in section 429.256(4), F.S. 1. As used in section 429.256(4)(g), F.S., the term "competent resident" means that the resident is cognizant of when a medication is required and understands the purpose for taking the medication. 2. As used in section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (g) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to follow the correct procedures outlined by the state when assisting one out of 40 sampled residents (Resident # 40). Findings Include:	A 052		

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A 052	Continued From page 46 On at 8:23 AM, observed Staff M outside of # dispensing medications in a small transparent cup. Staff M then followed to enter # with the small cup, measured Resident # 40's temperature and saturation, and shook the cup of medications onto Resident # 40's . Staff M did not open the medication container and removed the prescribed amount of medication in the presence of the resident. On at 8:28 AM, regarding on instructions to assist with medications, Staff M stated, "I take their , , their temperature, and saturation. I prepare them out here because I can't go inside with the cart". A review of Staff M's records showed a Certificate of In-Service Training of 2 hours for Assistance with Self - Administration of Medication dated . Class III	A 052		
A 055 SS=E	59A-36.008(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out	A 055		

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A 055	Continued From page 47 of sight of other residents. (b) Both prescription and over-the-counter medications for residents must be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed; 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or 6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in rule 59A-36.006, F.A.C. (c) Centrally stored medications must be: 1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times; 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to	A 055		

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A 055	Continued From page 48 the medication storage areas at all times; and, 4. Kept separately from the medications of other residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider. (e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation and Interview the facility failed to keep medication secured for two out of thirty-nine sampled residents (Residents # 33 &	A 055		

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A 055	Continued From page 49 3) Findings Included: On . . . . . at 8:23 AM, observation showed that the facility's medication cart was unlocked on the second floor of building # 4 On . . . . . at 8:28 AM, Staff T stated, "I have to lock it every time. It slipped my mind. It was my fault." Observation on . . . . . at 8:42 am revealed that the medication cart in building 5, on the top floor, was left unlocked with the keys placed on top of the cart (photographic evidence obtained). On at 8:45 am the Certified Nursing Assistant did not respond when asked why her keys were left unattended, and the medication cabinet unlocked. Class III	A 055		
A 079 SS=G	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	A 079		

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A 079	Continued From page 50 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 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	A 079		

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A 079	Continued From page 51 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 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	A 079		

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A 079	Continued From page 52 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 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.	A 079		

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A 079	Continued From page 53 (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 interview, the facility failed to ensure sufficient staffing was available to meet residents' scheduled and unscheduled needs. Twenty-seven residents experienced forty [redacted] from [redacted] through [redacted]. As a result of those [redacted], 14 of the 27 residents (#1, #3, #4, #5, #6, #7, #8, #9, #11, #12, #14, #23, #25, and #27) sustained injuries such as [redacted] bleeds, [redacted], and [redacted]. Eight of the 14 injured were hospitalized (Residents # 3,4,5,6,7,8,9,14). Findings included: Review of the staffing schedule revealed for [redacted] through [redacted] revealed, one Licensed Practical Nurse (LPN), one medication technician, and three Certified Nursing Assistants (CNA) were scheduled during the morning shift, from 7 AM-3:30 pm, and the afternoon shift, from 3:00 PM-11:30 PM. One CNA was assigned to each floor of the three-story buildings. Further review of the staffing schedule revealed one Licensed Practical Nurse (LPN), one medication technician, and two Certified Nursing Assistants	A 079		

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A 079	Continued From page 54 (CNA) were scheduled during the overnight shift, from 11 PM-7 AM. Two CNA's were assigned to cover each floor of the three-story building. Review of the staffing levels showed: through = 1672 staff hours. through = 2256 staff hours. through = 2106.5 staff hours. through = 2232 staff hours. through = 2272.5 staff hours. through = 2376 staff hours. through = 2248 staff hours. Review of the staffing schedules and facility census showed that the facility had 161 residents at these times and was required to have 707 staff hours weekly. While this ratio met the minimum requirement identified in the statute, staffing was insufficient to meet the scheduled and unscheduled needs of residents. During an interview on at 12:45 PM, the administrator and the Director of Nursing (DON) stated that "Of the 161 residents at the facility, 61 residents needed assistance with ambulation, 100 residents needed assistance with bathing, 84 residents needed assistance with , 8 residents needed assistance with eating, 62 residents needed assistance with grooming, 43 residents needed assistance with toileting, and 45 residents needed assistance with transferring. Upon further interview, the administrator and DON stated 13 residents were at risk of elopement, 93 residents needed precautions, and 7 residents needed total care. Interviewed on at 8:46 am, the Administrator stated that one CNA was responsible for the residents on each floor.	A 079		

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A 079	Continued From page 55 A review of the records for Residents #41, 42, 43, 44, 45, 46, and 47, who were receiving hospice services and required total care showed no documentation that the facility provided additional staffing to address resident needs. According to the National Institutes of Health "risk factors that have been correlated with [illegible] development are [illegible] years and older, current smoking history, dry skin, low [illegible] mobility, [illegible] (i.e., [illegible]), [illegible] and fecal [illegible], [illegible], physical [illegible], malignancy, history of [illegible], and white race." According to the National Institutes of Health "Adults who have been assessed as being at high risk of developing a [illegible] are encouraged to change their position frequently and at least every 4 hours." A review of facility incident reports, nursing notes, and resident records showed that 27 residents between [illegible] through [illegible], During an interview on at 1:30 PM, the DON stated that "the facility conducts frequent rounds on the residents. We have pull in the rooms and all residents receive a life alert necklace for free. We do our rounds every hours and all staff including housekeeping checks on the residents." A review of the facility's registered life alert pendant records revealed that only 131 residents out of 162 residents had the call pendant. On at 4:45 PM when asked why all	A 079		

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A 079	Continued From page 56 the residents did not have a call pendant, the administrator stated, "We changed the system for the pendants and some of the residents through the cracks." Review of incident reports revealed the life alert pendant company notified the facility of Resident #6's on and . There was no documentation that the facility's onsite staff was aware of the resident's before the notification. Further review of incident reports also revealed that Resident #23's son notified the facility of her on . There was no documentation that the facility's onsite staff was aware of the resident's before the notification. Additional review of incident reports Resident #9's wife notified the facility of his on , , and . There was no documentation that the facility's onsite staff was aware of the resident's before the resident's wife called. Review of incident reports revealed that Resident #26's roommate notified the facility of her on . (Cross reference A0025). There was no documentation that the facility's onsite staff was aware of the resident's before the roommate informed staff. On at 11:50AM, when asked for a record each time a call pendant was used, no documentation the facility's review of these records was provided. The administrator stated "We ask the company and the company will send the information. I have to see if they will be able to provide it to me." On at 1:31 PM, the administrator	A 079		

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A 079	Continued From page 57 stated, "we implement the rounds every hour or as soon as possible to keep an , on the residents." However, a review of the facility's records showed no documentation of the alleged rounds staff conduct every 2 - 3 hours. During an interview with the DON on at 12:44 PM, when asked whether there was documentation of the staff conducting the rounds, she stated, "no, we don't document the rounds." During an interview on at 12:45 PM, Staff J (Certified Nursing Assistant (CNA) stated that all calls go to the nursing station and a Licensed Practical Nurse (LPN) responds to the call. During an interview on at 1:30 PM, The DON stated that "we are doing everything we can. This is an elderly community and the elderly a lot, that is part of their aging process." Review of the facility's list of residents who need supervision and assistance with Activities of Daily Living (ADLs) revealed, 38 residents needed supervision with ambulation, 32 residents needed supervision with bathing, 27 residents needed supervision with , 22 residents needed supervision with eating, 35 residents needed supervision with grooming, 30 residents needed supervision with toileting, and 32 residents needed supervision with transferring. Review of the facility's incident reports revealed fifteen occurred on the 7 AM- 3:30 PM shift, twenty-three occurred on the :30 PM shift, and eight occurred on the 11 PM- 7 AM shift. (cross reference A0025) Review of facility records revealed that on the first	A 079		

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A 079	Continued From page 58 floor of building four, four residents needed assistance with ambulation, nine residents needed assistance with bathing, eight residents needed assistance with [redacted], one resident needed assistance with eating, six residents needed assistance with grooming, five residents needed assistance with toileting and four residents needed assistance with transferring. Further review revealed one resident needed supervision with ambulation, two residents needed supervision with bathing, three residents needed supervision with [redacted], one resident needed supervision with eating, three residents needed supervision with grooming, one resident needed supervision with toileting and one resident needed supervision with transferring. On the second floor of building four, records revealed that six residents needed assistance with ambulation, seventeen residents needed assistance with bathing, fifteen residents needed assistance with [redacted], fifteen residents needed assistance with grooming, seven residents needed assistance with toileting and seven residents needed assistance with transferring. Further review revealed five residents needed supervision with ambulation, three residents needed supervision with bathing, three residents needed supervision with [redacted], one resident needed supervision with eating, eleven residents needed supervision with grooming, two residents needed supervision with toileting and three residents needed supervision with transferring. On the third floor of building four, records revealed that four residents needed assistance with ambulation, seven residents needed assistance with bathing, seven residents needed assistance with [redacted], one resident needed assistance with eating, six residents needed	A 079		

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A 079	Continued From page 59 assistance with grooming, three residents needed assistance with toileting, four residents needed assistance with transferring, and one resident required total care. Further review revealed three residents needed supervision with ambulation, four residents needed supervision with bathing, two residents needed supervision with [illegible], one resident needed supervision with eating, four residents needed supervision with grooming, five residents needed supervision with toileting and three residents needed supervision with transferring. Review of incident reports revealed that on [illegible] Resident #3 and Resident #4 at the facility at 11 AM and were hospitalized. Resident #3 was hospitalized with a [illegible] injury and required staples and stitches in the top of the [illegible]. Resident #4 was hospitalized with a [illegible] of the [illegible], and punctate [illegible] of the frontal [illegible]. Further review revealed that Resident #3 and #4 lived on the second floor of building four. (Cross reference A0025) Review of the staffing schedule revealed that on [illegible] from 7 AM-3:30 PM in building four, there was one LPN, one med tech, one CNA scheduled to the second floor and one CNA scheduled to the third floor. Further review revealed the two CNA's scheduled to floors two and three were also scheduled to cover floor one. Review of facility records revealed that on the first floor of building five, six residents needed assistance with ambulation, eleven residents needed assistance with bathing, eight residents needed assistance with [illegible], four residents needed assistance with grooming, two residents needed assistance with toileting, five residents needed assistance with transferring, and two	A 079		

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A 079	Continued From page 60 residents required total care. Further review revealed eight residents needed supervision with ambulation, four residents needed supervision with bathing, five residents needed supervision with [illegible], three residents needed supervision with eating, five residents needed supervision with grooming, six residents needed supervision with toileting and six residents needed supervision with transferring. Review of facility records revealed that on the second floor of building five, nine residents needed assistance with ambulation, twelve residents needed assistance with bathing, eleven residents needed assistance with [illegible], one resident needed assistance with eating, seven residents needed assistance with grooming, seven residents needed assistance with toileting, eight residents needed assistance with transferring, one resident required total care. Further review revealed two residents needed supervision with ambulation, four residents needed supervision with bathing, two residents needed supervision with [illegible], one resident needed supervision with eating, three residents needed supervision with grooming, two residents needed supervision with toileting and two residents needed supervision with transferring. Review of facility records revealed that on the third floor of building five, five residents needed assistance with ambulation, twelve residents needed assistance with bathing, eleven residents needed assistance with [illegible], six residents needed assistance with grooming, eight residents needed assistance with toileting and eight residents needed assistance with transferring. Further review revealed eight residents needed supervision with ambulation, one resident needed supervision with bathing, one resident needed	A 079		

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A 079	Continued From page 61 supervision with [illegible], three residents needed supervision with grooming, one resident needed supervision with toileting and four residents needed supervision with transferring. Review of incident reports revealed that on [illegible] Resident #6 [illegible] at the facility at 6:40 AM and was hospitalized with a [illegible]. Further review revealed that Resident #6 lived on the third floor of building five. (Cross reference A0025) Review of the staffing schedule revealed that on [illegible] from 11 PM-7:30 am in building five, there was one CNA scheduled to the first floor and one CNA scheduled to the third floor. There was one LPN scheduled from 12AM-8:30 AM. Further review revealed the two CNA's scheduled to floors one and three were also scheduled to cover floor two. Review of facility records revealed that on the first floor of building two, four residents needed assistance with ambulation, twelve residents needed assistance with bathing, eleven residents needed assistance with [illegible], one resident needed assistance with eating, seven residents needed assistance with grooming, five residents needed assistance with toileting, four residents needed assistance with transferring. Further review revealed seven residents needed supervision with ambulation, three residents needed supervision with bathing, two residents needed supervision with [illegible], one resident needed supervision with eating, four residents needed supervision with grooming, five residents needed supervision with toileting and six residents needed supervision with transferring. Review of facility records revealed that on the	A 079		

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A 079	Continued From page 62 second floor of building two, five residents needed assistance with ambulation, thirteen residents needed assistance with bathing, thirteen residents needed assistance with [illegible], two residents needed assistance with eating, nine residents needed assistance with grooming, seven residents needed assistance with toileting, seven residents needed assistance with transferring, and two residents required total care. Further review revealed five residents needed supervision with ambulation, one resident needed supervision with bathing, one resident needed supervision with [illegible], four residents needed supervision with eating, four residents needed supervision with grooming, five residents needed supervision with toileting and five residents needed supervision with transferring. Review of facility records revealed that on the third floor of building two, seven residents needed assistance with ambulation, ten residents needed assistance with bathing, ten residents needed assistance with [illegible], three residents needed assistance with eating, eight residents needed assistance with grooming, seven residents needed assistance with toileting and six residents needed assistance with transferring. Further review revealed four residents needed supervision with ambulation, seven residents needed supervision with bathing, three residents needed supervision with [illegible], two residents needed supervision with eating, two residents needed supervision with grooming, three residents needed supervision with toileting and three residents needed supervision with transferring. Review of incident reports revealed that on [illegible] Resident #8 at the facility at 10:15 AM and was sent to urgent care with a large	A 079		

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A 079	Continued From page 63 hematoma to the right side of the . . . . Further review revealed that Resident #8 lived on the second floor of building two. (Cross reference A0025) Review of the staffing schedule revealed that on . . . . . from 7 AM-3:30 PM in building two, there was one LPN, one med tech, one CNA scheduled to the first floor, one CNA scheduled to the second floor, and one CNA scheduled to the third floor. Class II	A 079		
A 093 SS=G	59A-36.012(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2010, which are incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04003, and the current summary of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2010, which are incorporated by reference and available for review at: http://iom.edu/Activities/Nutrition/SummaryDRIs/~/media/Files/Activity%20Files/Nutrition/DRIs/New%20Material/5DRI%20Values%20SummaryTables%2014.pdf. Therapeutic diets must meet these nutritional standards to the extent possible. (b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the residents, and must be prepared through the use	A 093		

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A 093	Continued From page 64 of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes. (c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on the menus or on a separate sheet. 1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. 2. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents. (d) Menus must be dated and planned at least 1 week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months. (e) Therapeutic diets must be prepared and served as ordered by the health care provider. 1. Facilities that offer residents a variety of food choices through a select menu, buffet style	A 093		

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A 093	Continued From page 65 dining, or family style dining are not required to document what is eaten unless a health care provider's order indicates that such monitoring is necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility. 2. The facility must document a resident's refusal to comply with a therapeutic diet and provide notification to the resident's health care provider of such refusal. (f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals must be evenly distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of [illegible] the time between meals. (g) Food must be served attractively at safe and palatable temperatures. All residents must be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, must be on [illegible] (h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has with residents to serve, must be on [illegible] at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must also be stored, or the facility must have a plan for obtaining water in an emergency, with the plan	A 093		

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A 093	Continued From page 66 coordinated with and reviewed by the local disaster preparedness authority. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure therapeutic diets were prepared and served as ordered by a healthcare provider for three out of 40 sampled residents (Resident # 8, # 18, and # 38). The facility also failed to have a regular and therapeutic menu reviewed annually by a licensed or registered dietician. Findings included: 1) On at approximately 9 AM, observed in # , a medium sized yellow banana on top of the kitchen counter, four red apples in the refrigerator, a small cup of orange juice, a pastry, a cup of coffee with two sugar substitutes, two creamer cups, and one cup of Raisin Bran cereal. A review of the facility's census log revealed Resident # 38 lived in # . A review of Resident # 38's health assessment dated showed Resident # 38 had special diet instructions for a 'Simplified diet, regular texture, regular liquid consistency.' Further review of Resident # 38's health assessment showed Resident # 28 had a medical history and diagnoses of [illegible] Hyperuricemia, Murmur, and	A 093		

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A 093	Continued From page 67 . Under 'Nursing/treatment/ Service Requirements', the health assessment showed Resident # 38 needed services. A review of Resident # 8's demographic sheet revealed that Resident # 8 went to three times a week. A review of Resident # 8's health assessment dated showed Resident # 8 had special diet instructions for a ' Diet' and 'No Salt Added'. Further review of Resident # 8's health assessment showed Resident # 8 had a medical history and diagnoses of , and , stage 5. A review of Resident # 18's health assessment dated had special diet instructions for a ' Diet'. Further review of Resident # 18's health assessment showed a medical history and diagnoses of , Hyperlipemia, in Under 'Nursing/treatment/ service requirements', the health assessment revealed Resident # 18 was ' dependent. On 3x weekly'. According to the National Foundation, ' is a treatment that does some of the things done by healthy . It is needed when your own can no longer take care of your body's needs. You need when you develop --usually by the	A 093		

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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 093	Continued From page 68 time you lose about 85 to 90 percent of your , function. According to Nephcure , International, 'People with compromised , function must adhere to a or , diet to cut down on the amount of waste in their . A diet is one that is low in , , , , and protein'. Furthermore, Nephcure , International explained 'When the , fail, they can no longer remove excess , so , levels build up in the body. High in the is called hyperkalemia which can cause: , An irregular heartbeat, slow , , and '. It also showed that foods high in , were 'Avocado, Banana, Potatoes, Spinach, Beans, Citrus Juices, and Fish'. Additionally, the National , Foundation explained 'When your , fail, , keeps your body in balance by: removing waste, salt and extra water to prevent them from building up in the body; keeping a safe level of certain chemicals in your , such as , , and ; helping to control , '. On at 10:24 AM, the facility's Dietary Director stated that the facility's breakfast was served as a 'courtesy' for all the residents in the facility which included coffee, milk, pastries, juice, and cereal. The Dietary Director also acknowledged that the facility did not have an individualized menu for residents who received services. Further interview with the Dietary Directory revealed that residents who receive should not be given .	A 093		

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	AL11910916	A. BUILDING: _____ B. WING _____	02/15/2021

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A 093	Continued From page 69 On at 12:19 pm, the facility's Dietician stated that a diet should avoid the use of additional salt and avoid foods with , . A review of resident records revealed 23 residents (Resident # 1, # 2, #, 3, # 4, # 5, # 6, # 8, # 9, # 10, # 12, # 13, # 14, # 17, # 20, # 22, # 27, # 28, # 31, # 32, # 35, # 37, # 39, and # 40) were on a 'No Added Salt' diet. 11 residents (Resident # 5, # 11, # 14, # 17, # 27, # 28, # 32, # 35, # 37, # 39, and # 40) were on a 'Low Fat/Low ' diet. Three residents (Resident # 5, # 6, # 9, and # 37) were on a 'Mechanical Soft' diet. Four residents (Resident # 6, # 13, # 27, # 36) were on a 'Calorie Controlled' diet and three residents (Resident # 10, # 15, and # 34) were on a 'Pureed' diet. 2) On during the tour of the facility, observed a cart in Building # 2 with the following breakfast items: A box of assorted pastries, a large brewed coffee container, small blue boxes of 2% reduced fat milk, 4 oz. cups of assorted juices. Observation on at 9:39 AM showed there was a menu posted on the hallway next to one of the entrances to the dining room. Further observation showed that breakfast was not listed; the posted menu only covered lunch and dinner. The posted menu showed a review date of and there was no documentation of a menu for 2020. Further review of the facility's menu showed a 'Diet Spreadsheet' with a signature on the bottom	A 093		

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A 093	Continued From page 70 right corner in red ink; however, the year was 'whited out' and had '2020' written over the whitened area. On [redacted] at 12:19 PM, the facility's dietician stated that she signed the menus every year and breakfast was considered a daily meal. Class II	A 093		
A 152 SS=I	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable [redacted] to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, [redacted] or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested.	A 152		

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A 152	Continued From page 71 (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . . . . . . This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that the facility was safe and free of hazards. Findings included: 1) On . . . . . at 8:16 AM, observed in the unlocked laundry room in Building # 4 a transparent Tropicana Orange Juice bottle filled with a light blue colored liquid. Additional observation revealed a transparent water bottle with a light blue colored liquid stored in a hamper of clothes. Interviewed on . . . . . at 8:17 AM, Staff O stated regarding the unlocked laundry room, "It's open from 7 AM - 7 PM. They shouldn't be leaving it unlocked". Interviewed on at 11:40 AM the Administrator stated, "I really don't know why they would put that in there." "It looks like detergent or fabric softener." According to the . . . . 's Association: "A person living with . . . may be more prone	A 152		

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A 152	Continued From page 72 to safety hazards in certain areas of the home or outdoors. Monitoring garages, work rooms, basements, and outside areas, where there are more likely to be tools, chemicals, cleaning supplies and other potentially hazardous items" A review of the facility's records showed a document that listed Residents # 29, # 30, # 31, # 32, # 33, # 34, # 35, and # 36 as 'Building # 4 Residents with 's & '. 2) On during the tour of the facility at approximately 7:45 an, observed a Styrofoam cup filled with a dark liquid, two sugar packets, a scrunched-up paper napkin two empty plastic containers, and a white stained lid left unattended in the corner of a bench outside of the dining area. On at 7:45 AM observed a rusty dryer in the laundry area and a Rusty, metal patio chair next to the laundry area in Building # 5. On at 7:52 AM observed a section of the wall in Building # 5 had uneven and/or missing paint. During an interview on at 7:58 AM, the facility's contractor stated, "I'm working on painting the facility." During an interview on at 4:26 PM, the Director of Nursing (DON) stated, "we are painting building 5, that building is getting renewed. We tried to do an abstract color on each of the buildings, so residents with issues know which building they are in. It has uneven paint because that's how we do it."	A 152		

Agency for Health Care Administration

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A 152	Continued From page 73 On . . . . . at 08:10 AM, observed a 7- . . . dried-out Christmas tree on the second floor of the facility. There was no evidence of a fire extinguisher or water next to the Christmas tree. Class II	A 152		