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
	AL11965733	A. BUILDING: _____ B. WING _____	02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING AVENTURA	2777 NE 183rd ST AVENTURA, FL 33160

(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
CZ814	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12(2) Care Provider Background Screening Clearinghouse.- (b) Until such time as the [illegible] are enrolled in the national retained print notification program at the Federal Bureau of Investigation, an employee with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. (c) An employer of persons subject to screening by a specified agency must register with the clearinghouse and maintain the employment status of all employees within the clearinghouse. Initial employment status and any changes in status must be reported within 10 business days. (d) An employer must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee for electronic [illegible] submission to the Department of Law Enforcement. The registration must include the employee's full first name, middle initial, and last name; social security number; date of birth; mailing address; [illegible]; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain an updated roster the status within the background screening clearinghouse. Staff O, and CC, who no longer worked at the facility, were still listed. Findings included:	CZ814		

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CZ814	Continued From page 1 Review of the facility's roster showed Staff O had a hire date of , and no end date listed; Staff CC had a hire date of , and no end date listed. On , at 11:35 AM, the Regional Vice President stated, "In , I had to terminate the business office manager, who handled accounts, Staff CC. Staff O was let go in due to the way he communicated with his employees and other staff." Unclassified	CZ814		
CZ830	408.821 FS Emergency Management Planning 408.821 Emergency management planning; emergency operations; inactive license.- (1) A licensee required by authorizing statutes and agency rule to have a comprehensive emergency management plan must designate a safety liaison to serve as the primary contact for emergency operations. Such licensee shall submit its comprehensive emergency management plan to the local emergency management agency, county health department, or Department of Health as follows: (a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the agency within 30 days after submission of the plan. (b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan. (c) Submit necessary plan revisions within 30 days after notification that plan revisions are required. (d) Notify the agency within 30 days after approval of its plan by the local emergency	CZ830		

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CZ830	Continued From page 2 management agency, county health department, or Department of Health. (2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved comprehensive emergency management plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers. (3)(a) An inactive license may be issued to a licensee subject to this section when the provider is located in a geographic area in which a state of emergency was declared by the Governor if the provider: 1. Suffered damage to its operation during the state of emergency. 2. Is currently licensed. 3. Does not have a provisional license. 4. Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months. (b) An inactive license may be issued for a period not to exceed 12 months but may be renewed by the agency for up to 12 additional months upon demonstration to the agency of progress toward reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for the inactive license, which states the beginning and ending dates of inactivity and includes a plan for the transfer of any clients to other providers and appropriate licensure fees. Upon agency approval, the licensee shall notify clients of any	CZ830		

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CZ830	Continued From page 3 necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases operations. The end of the inactive period shall become the license expiration date, and all licensure fees must be current, must be paid in full, and may be prorated. Reactivation of an inactive license requires the prior approval by the agency of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part and applicable rules and statutes. (4) The agency may adopt rules relating to emergency management planning, communications, and operations. Licensees providing residential or inpatient services must utilize an online database approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to report their positive COVID-19 resident cases on the agency's Emergency Status System, (ESS). Findings included: Review of the agency's ESS showed the facility reported 0 positive COVID-19 residents for [redacted]. On [redacted] at 9:30 AM, Staff D stated that one resident was at the hospital with COVID-19, Resident 14. On [redacted] at 11:35 AM, the Regional Vice President stated, "The administrator was doing that, and also Staff BB; I will follow up on that; We thought the administrator was coming	CZ830		

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CZ830	Continued From page 4 . . . this week, but she is not, and she used to do most of those updates." Unclassified	CZ830		

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A 000	Initial Comments Complaint surveys (#2020019629, #2020006260,# 20200141) and a COVID-19 monitoring were conducted on through .Deficiencies were identified at time of the survey.	A 000		
A 025 SS=J	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 record review, and interview, the facility failed to provide adequate staff to meet residents scheduled and unscheduled needs. Two residents were left on the floor for several hours after using a pendant or room alarm to call for assistance from staff and received no medical assessment for injury (Residents #1 and #2). Resident #1 suffered a black , and other . There were 2,203 resident calls for assistance from 58 of 150 sampled residents, over a twelve-week period, and the calls were cancelled after residents received no response in 25 minutes. This affected Residents #1, 2, 3, 6, 7, 8, 18, 31,	A 025		

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A 025	Continued From page 2 25, 26, 27, 28, 29, 30, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 76, 77 and 79). Staff provided no assistance to residents after the calls for help timed out in the facility's call system. Findings included: A review of the facility records regarding staff responses to residents' call for assistance showed that 58 of 120 residents did not receive help. 1) During an interview on at 2:20 pm with Resident #5 regarding getting assistance from staff, the resident stated, "I am Ok, but when I ring the bell, they take a while to come and when they come, they are upset, like if they don't want to help you." 2) On at 3:30 PM, Resident #2 was observed with a black and blue below the right , and two on the right . In an interview with Resident #2 on at 3:35 PM, the resident stated that she had a bad the previous Thursday ( ) when she was coming out of the bathroom. The resident stated that she called three times and she was told staff would send someone, 'but they never came.' The resident also complained of a strong lower , that was aggravated due to the . The resident ranked the , at 15 from a , scale of 0 to 10 with 0 meaning no , and 10 the worse , possible. A review of the resident's record showed that she had a medical history of lower , and was prescribed , Patch and , ER (Extended Release) tablet.	A 025		

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A 025	Continued From page 3 A review of the facility's incident report dated [redacted] at 4:30 PM showed that staff documented, "While doing rounds, resident observed on bathroom floor in a sitting position. Resident stated she slipped while coming out the bathroom." A review of the resident record showed no documentation of medical care or follow up to determine the resident's needs for assistance to avoid further [redacted]. According to the US National Library of Medicine, "[redacted] patches are used to relieve severe [redacted] in people who are expected to need [redacted] medication around the clock for a long time and who cannot be treated with other medications. [redacted] is in a class of medications called opiate ([redacted]) [redacted]. It works by changing the way the [redacted] and nervous system respond to [redacted]." According to the US National Library of Medicine, "[redacted] is used to relieve moderate to severe [redacted] extended-release tablets and capsules are only used to relieve severe (around-the-clock) [redacted] that cannot be controlled by the use of other [redacted] medications. [redacted] extended-release tablets and capsules should not be used to treat [redacted] that can be controlled by medication that is taken as needed. [redacted] is in a class of medications called opiate ([redacted]) [redacted]. It works by changing the way the [redacted] and nervous system respond to [redacted]." During an interview on [redacted] at 9:15 am, Staff D (a Licensed Practical Nurse and Floor Supervisor) stated, "the facility installed two devices for the residents to notify the staff in case of an emergency. The facility installed a call light in each resident's room, except for the third floor."	A 025		

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A 025	Continued From page 4 3) Interview on at 11:00 AM with Resident #18, he stated, "I am ok, but when I ring the bell, they take a while to come and when they come, they were upset, like if they don't want to help you." During a second interview by phone on at 4:45 PM, the resident stated, "When I call, usually is for them to watch me when I go to the bathroom to make sure I don't , otherwise, I move very good with my electric chair." 4) A review of the pendant and room call light log, which documented when residents pressed an alert when they needed staff assistance, revealed 5,393 calls were made by residents between through . Further review revealed, there were 2,203 unanswered calls with a response time of "end of chain". When asked what "End of Chain" meant, Staff D stated on at 9:17 am, that 23 minutes after a resident presses a call light or pendant, the alarm resets automatically if the staff has not responded. She further stated, two minutes later, if there has been no response by 25 minutes from the time of the initial call, the call signal turns itself off. Review of the pendant alarms and room call light log for the period of to for the 2nd, 4th, 5th, 6th, 7th and 8th floors, showed the following calls were not responded to included: For the 2nd Floor-371 calls made; 191 calls were not answered in more than 25:04 minutes (End of chain). This equals to 51% of calls during this period. For the 4th Floor-1450 calls were made; 862 calls	A 025		

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A 025	Continued From page 5 were not answered in more than 25:04 minutes (End of Chain). This equals 59% of calls during this period. For the 5th Floor-1701 calls were made; 790 calls were not answered in more than 23:04 minutes (End of Chain). This equals 46% of calls during this period. For the 6th Floor-1349 calls were made; 193 calls were not answered in more than 23:04 minutes (End of Chain). This equals 14% of calls during this period. For the 7th Floor-398 calls were made; 122 calls were not answered in more than 23:04 minutes (End of Chain). This equals 31% of calls during this period. For the 8th Floor-127 calls were made; 43 calls were not answered in more than 23:04 minutes (End of Chain). This equals 34% of calls during this period. Further review of facility records found no documentation of staff actions to assist the 56 residents when the 2,203 alarms turned off at the end of the chain. Facility record review revealed, that Residents #26, 27, 28 and 31 had more than 40 calls for assistance that resulted in an "end of chain" response, meaning no assistance was received for at least 25 minutes. A review of the pendant and room call light log showed Resident #26 had 48 "end of chain" results from his calls for assistance between [redacted] and [redacted]. A review of Resident #26's health assessment dated [redacted] showed the resident had a medical history and diagnoses of [redacted] ([redacted]), Diastolic and [redacted]	A 025		

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A 025	Continued From page 6 , and . Physical limitation: Needed transfer assistance from one person to go to the bathroom. The resident required assistance with ambulation, bathing, , self- care, toileting, transferring. A review of the pendant and room call light log showed that Resident #27 had 125 "end of chain" results from his calls for assistance between and . A review of Resident #27's health assessment showed the resident had a medical history of Atherosclerotic , , and . Physical limitation: Uses Walker. The resident required assistance with all activities of daily living. A review of the pendant and room call light log showed that Resident #31 had 201 "end of chain" results from her calls for assistance between and . A review of Resident#31's health assessment dated on showed the resident had medical history and diagnoses of , , , and ( ). Physical limitation: Ambulates with rolling walker. The resident required assistance with bathing and , supervision with eating, grooming, and toileting. A review of the pendant and room call light log showed that Resident #28 had 456 "end of chain" results from her calls for assistance between and . A review of Resident #28's health assessment showed the resident had medical history and diagnoses of , ,	A 025		

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A 025	Continued From page 7 { }, and . The resident required assistance with ambulation, bathing, , grooming, toileting and transferring. On At 05:02 AM Staff PP, a Certified Nursing Assistant (CNA) stated, "I am the only employee working on the 5th floor and there are 20 residents now. I work as a certified nursing assistant (CNA) from 11:00pm to 7:30 am. When someone is off, the Wellness Director splits the work between us. Like yesterday, I had these same 20 residents and some additional residents from the 4th floor. I give them a shower and I usually start at 6 AM so I can finish. If I need a break, I would ask the girl from the eighth floor and if she is not busy, she would cover for me. It's overwhelming. They want you to do everything for $10.00 per hour." In an interview with Resident #1's brother/Power of Attorney (POA) on at 12:58 PM, the POA stated the resident had numerous times, and had complained of not getting help before. He further stated that the family installed a camera in Resident #1's bedroom. He stated that during the , while observing the resident via the camera, he observed Resident #1 on the floor. He called the facility to inform the staff that Resident #1 had , however no one answered the phone. He stated, he continued to watch the camara to see if someone would come to assist the resident. He said Resident #1 stayed on the floor and did not receive assistance from off the floor until four hours later from a staff on the next shift. The family member stated that he did not recall the exact date or time of the incidents. Further review of facility records showed that	A 025		

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A 025	Continued From page 8 Resident #1 had also . . . on . . . . and due to . . , received an . , on . . . Review of the staffing schedule for the night and morning shifts showed 34 staff members provided care to the residents. Observations on . . . . . at 4:00 AM during the overnight shift (11pm-7pm), showed there were only 6 staff on duty, including CNA (Certified Nursing Assistants) and Medication Technicians (Med Techs). Observations on . . . . . at 4:00 AM found one staff was assigned to each floor on the 2nd, 5th, 6th, 7th, and 8th floors. Further record review and observation showed that no staff were assigned to the fourth floor. On . . . . . at 05:05 AM, Staff QQ (CNA) stated, "when someone is off, the Director of Nursing (DON) splits the work between us." On . . . . . at 4:22 am, Staff V (CNA/Med Tech) stated that she and another staff split the work on the fourth floor because no one was assigned there. On at 12:20 PM, Resident #18's family member stated, "They take a long time to come to the room when he calls." Interview on at 3:25 PM Staff X (Valet/Driver) stated," Sometimes residents tell me that they call for assistance and no one comes, so I report it to the front desk. The thing with the staff is, that sometimes you don't see them, you don't know in what room they are." Class I	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 027	Continued From page 9	A 027		
A 027 SS=G	59A-36.007(3) FAC Resident Care - Arrangement for Health Care (3) ARRANGEMENT FOR HEALTH CARE. In order to facilitate resident access to health care as needed, the facility must: (a) Assist residents in making and remind residents about scheduled for medical, dental, nursing, or mental health services. (b) Provide transportation to needed medical, dental, nursing or mental health services, or arrange for transportation through family and friends, volunteers, taxi cabs, public buses, and agencies providing transportation. (c) The facility may not require residents to receive services from a health care provider. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to facilitate in a timely manner a diagnostic test ( ) and failed toto schedule a follow-up medical assessment for three out of 18 sampled residents (Resident #1 and Resident #2, and Resident #9). Resident #2 received no medical assessment from her Primary Care Provider for the resident and for six days after a Resident #1 received no medical care after a . Finding include: 1) At 3:30 PM on , Resident #2 was observed with black and blue below the right and two on the right . In an interview with Resident #2 on at 3:35 PM, the resident stated that she had a bad	A 027		

Agency for Health Care Administration

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A 027	Continued From page 10 the previous Thursday ( ) when she was coming out of the bathroom. The resident stated that she called three times and she was told they would send someone, but they never came. The resident also complained of a strong lower , that was aggravated due to the . The resident ranked the , at 15 from a , scale of 0 to 10 with 0 meaning no , and 10 the worse , possible. The resident has a medical history of lower , . The resident currently takes the following , medications in the facility. They are , Patch and , . ER tablet. In an interview with Staff D on at 9:56 AM, Staff D stated that she saw the resident the previous Friday ( ). She saw that the resident right , was "black and blue". No noted. I got an order for , . Staff D also stated that the physician and her family were notified of the incident. A review of the Resident #2's Health Assessment dated showed that the resident was admitted to the facility on . Medical History and Diagnoses included low , , , major , , type II, , and , ( ) .As for Activities of Daily Living (ADL), the resident was independent with ambulation, eating, self-care (grooming), and toileting. The resident needed supervision with bathing, , and transferring, and assistance with self-administration of medications. A review of the facility's incident report dated at 4:30 PM showed that staff documented "While doing rounds, resident observed on	A 027		

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A 027	Continued From page 11 bathroom floor in a sitting position. Resident stated she slipped while coming out the bathroom. Resident was evaluated by Med/Tech and resident stated she does not want to go to the hospital. Resident was assisted from the floor."(sic) A review of Resident #2's Observation notes dated more than 14 hours later on at 7:05 AM showed, Staff D wrote "received report from lead Med/Tech [medication technician] stating during previous day 3 PM-11 PM shift, it was reported while assigned C.N.A. [Certified Nursing Assistant] was doing rounds. Resident was observed in a sitting position on her bathroom floor. When C.N.A. asked what occurred, the resident stated she slipped while she was coming out of the bathroom. The C.N.A. then called the assigned med/tech and after further evaluation and resident stating she was fine; no injuries were noted. She was assisted from the floor by the C.N.A. and the Med/tech into her bed. Resident's Power of Attorney (POA) and the Primary Care Provider (PCP) were notified." In a review of the Resident #2's Observation notes dated at 8:15 AM, Staff D wrote "During rounds, resident was observed in her apartment lying in bed. While evaluating the resident, she was alert and in stable condition. Resident was asked what occurred, she stated to me she was coming out of the bathroom and slipped the day before. When asked, resident denied any , or discomfort at present time. Small black and blue area noted under her right . Resident denied feeling any , or discomfort in the area. Resident was reminded to use pendant when assistance is needed. Frequent checks by staff member will continue. "	A 027		

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A 027	Continued From page 12 A review of the Facility/Physician Communication Form dated " " at 10:00 AM showed a request for a physician's order for: , to right side of -frontal/side view, due to a . Further review showed no documentation that the date error had been corrected. A review of an email from Staff B on at 3:37 PM showed no clear information about the discrepancies in the dates of Resident #2's . The email stated, "so in speaking with the nurse on duty, Staff D, there was an error on the date of the , written on . The date was erroneously transcribed for . The , order and requisition were faxed to , provider on . Erroneous date was not noticed until yesterday, when inquiring about the results. After being notified that , had not been rendered, the , provider was contacted on and the , was rendered. Results received on with no evidence of . Results were faxed to Physician #1". A review of Resident #2's , Interpretation Report dated confirmed that the resident had a , - 2 View, and there were no or displacements. In an interview with Resident #2's Primary Care Provider (Physician A) on at 12:33 PM, the primary care provider stated that the facility notified him of the resident's . The facility staff told him that there were no injuries. The provider stated that he does not remember the date or the time of the notification. As for documentation, he stated that since there were no injuries, he did not document the incident. The physician also stated that no medical orders were given to the facility. As for the , to the right side of the , he stated that he does not know the result. He also stated that he did not order the ,., and that it	A 027		

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A 027	Continued From page 13 was ordered by Physician B, a [redacted]. Finally, the Primary Care Provider stated that Physician B did not work in his office. In an interview with on [redacted] at 1:12 PM, Physician B's office staff, when asked if Resident #2 been one of their patients and for information on the results of the right side of [redacted], stated "there is no medical record regarding Resident #2. We have no information on her. The results could be in the facility". 2) A review of an Incident Reporting Form dated [redacted] at 12:35 AM, showed that Staff G stated that Resident #1 had a [redacted] in her bedroom. Staff G described the incident, "Certified Nursing Assistant (C.N.A.) observed the resident in sitting position on the floor besides the chair in the bedroom. No injuries noted. The resident was assessed, resident ambulated with no obvious sign of [redacted]. Resident was helped [redacted] to bed. Staff G notified the resident's emergency contact on [redacted] at 12:40 AM." Further review of the resident record showed no documentation that Staff G notified the resident's Primary Care Provider. There was no documentation that Resident #1 was sent to the hospital for assessment. A review of Resident #1's Resident Health Assessment dated [redacted] showed the resident had Medical History and Diagnoses of [redacted], and increase [redacted]. The resident was identified as a risk. Resident #1 required total care with bathing, [redacted], self-care (grooming), and toileting. The	A 027		

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A 027	Continued From page 14 resident was independent with ambulation, eating, and transferring. A review of the Resident #1's Observation Notes dated [redacted] at 7:30 AM showed Staff D wrote, "Received report from outgoing lead med/tech stating at approximately 12:35 AM while C.N.A. was doing rounds, resident was observed in a sitting position on the floor by her dining room chair. Resident was unable to state how she [redacted]. After further evaluation and with no obvious sign or symptom of injuries noted, resident was assisted up with two persons assist and ambulated [redacted] to her bed. Resident was assisted [redacted] into bed. Brother Power of Attorney (POA) notified". (sic) A review of the transcribed Incident Reporting Form dated [redacted], showed that Staff D wrote that "Resident #1's Primary Health Care provider was notified on [redacted] at 8:30 AM. The form further stated that Staff D notified [Physician #1]. Staff D also stated that the resident's emergency contact was notified on [redacted] at 12:40 AM. In an interview with Staff B on [redacted] at 10:15 AM, Staff B (Wellness Director) stated, "from what I recall, we did notify the doctor." Staff B could not verify if the resident was assessed by a physician. A review of the resident record did not show any follow-up by the physician. In an interview with Resident #1's POA on [redacted] at 1:07 PM, The POA further stated "that when he finally got in contact with the facility, management made him feel like he was lying and told him they would investigate it. The POA then sent the Wellness Director and the Administrator the video of the incident. The POA stated that the	A 027		

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A 027	Continued From page 15 family was informed that the staff received a disciplinary action plan and that the responsible staff member was terminated. A review of the resident record showed no documentation of actions that the facility took to prevent further [illegible] or coordinate medical care. Further review of facility records showed that Resident #1 had [illegible] on [illegible] and due to [illegible], received an [illegible] on [illegible]. There was no documentation of actions taken to prevent future [illegible]. 3) At approximately 1:30 PM on [illegible], it was observed that Resident #9's right [illegible] 2nd [illegible] was [illegible]. Redness was present only in the 2nd [illegible]. The resident was unable to be interviewed due to the resident's [illegible] status, to determine whether the 2nd [illegible] was painful. A review of Resident #9's Health Assessment dated [illegible] showed that the resident had a Medical History and Diagnoses of [illegible], type 2, [illegible], [illegible] phase. Physical or Sensory Limitations included abnormalities of gait and mobility, [illegible], unsteadiness on [illegible] or Behavioral Status was listed as alert and orientated x 1. Nursing/Treatment/ [illegible] Service Requirements showed Registered Nurse evaluation, [illegible]. The resident needed assistance with ambulation, bathing, [illegible], eating, self-care, toileting, and transferring, and assistance with	A 027		

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A 027	Continued From page 16 self-administration of medication. In a review of the Observation Notes for Resident #9 dated at 4:30 PM, Staff B (Director of Nursing/Wellness Director) documented, "non-pitting noted to lower extremities. Dry skin noted to heals. Podiatry to follow-up". In a review of the Observation Notes for Resident #9 dated at 9:05 AM, Staff B stated, "resident seen by Podiatrist. New orders received and carried out". In a review of the Resident #9's Podiatrist Examination Notes dated , the resident's chief complaint was painful toenails. The symptoms were in the toenails on both . The notes stated, "Examination: the resident has ankle and . Painful and toenails without any signs of . After the examination and treatment, the ALF were given the following instruction: resident's Aid instructed to check during shower and to inform the nurse in charge if there is open , , or any other abnormal changes. In an interview with the Podiatrist Assistant on at 11:54 AM, the Assistant stated, "the resident was seen by the Podiatrist on . The reason for the examination was to examine the toenails on both ". The Assistant stated, "the resident were including the 2nd on the right , but the 2nd did not present any redness. No medications were order. The only procedure that was done was to trim the toenails". Class II	A 027		

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A 032	Continued From page 17	A 032		
A 032 SS=G	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 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	A 032		

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A 032	Continued From page 18 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 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)(l), F.S. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to follow it policies and procedures regarding elopement and develop an elopement preventive plan for one out of eighteen sampled residents (Resident #4).The facility also failed to provide documentation of having conducted a minimum of two resident elopement prevention and response drills per year. Findings Included: 1}	A 032		

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A 032	Continued From page 19 On . . . . . at 10:00am, observation showed signage on the 3rd floor door which stated, "Do Not Open Door, Alarm Will Sound". State agency representative entered the third floor (memory care unit) from the stairwell area and entered the third floor No alarm was heard or sounded at the door. The memory care director asked, "How did you arrive on the third floor (Secured floor) without using code so fast?" State agency representative stated, "I took the stairs." Immediately, the Director of Memory Care stated, "That's not supposed to happen," then walked quickly to the door and was able to open it without the alarm sounding. Then contacted the of maintenance and notified him of the alarm system not working. According to American Association of Retired Persons (AARP), a "Memory care unit is a form of senior living that provides intensive, specialized care for people with memory issues. Many assisted living facilities and nursing homes have created special memory care units for . . . . . patients. There are also stand -alone memory care facilities. The memory care unit requires extra safety measure to meet the needs of the residents with memory , ..." A review of the adverse incident state agency database showed Resident #4 who lived on the third floor (Memory-care unit) was found by the community valet driver in the front of the building at 6:47am. The valet driver escorted the resident into the building and further assisted the resident to the secured memory care community which is where the resident resides. The report documented that on . . . . around 6:55am, the resident was evaluated for injury by the nurse on duty. The primary care physician and family member was notified.	A 032		

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A 032	Continued From page 20 A review of Resident #4's health assessment dated ... showed the resident was diagnosed with Generalized ..., Dyslipidemia and was admitted to memory care secured unit. The resident was not listed as an elopement risk. The physician indicated the resident was independent with ambulation and eating; needed supervision with grooming, toileting and transferring and needed assistance with bathing and ... The resident needed assistance with medications. A review of facility's elopement policies and procedures showed "residents at all levels will be assessed for the potential of ... and elopement. Residents deemed to be at the risk will be monitored. The resident service plan will outline methods of monitoring (use of monitoring device or bracelet, transfer to memory care program, or use of personal companion) In the event, a resident is identified as a elopement risk by assessment, the community will promote to minimize the risk of elopement. Further review of the facility's policies and procedures on elopement risk and assessment intervention procedure showed," the General manager and the Wellness Director are responsible for overall rollout and monitoring of elopement policy and procedures. Implementation of Quarterly Elopement drill, forwarding of drills results to Solvere Living Regional Director, QA review at Safety Committee meeting quarterly, provision/arrangement of staffing needs as indicated. 2. The Wellness Director is responsible for the completion of assessment and intervention and to ensure all doors other than the main entrance should be alarmed otherwise monitored or secured. The facility failed to follow	A 032		

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A 032	Continued From page 21 it policies regarding preventive intervention due to the stairwell door being unlocked and accessible to enter the third floor. In the event of an elopement, the community has "zero tolerance" policy regarding elopement. A resident exhibiting signs of exit- seeking behavior who repeatedly attempts to or does away from the community will revaluated for their ability to remain living safety in the memory care unless the family promptly provides one to one 24-hour caregiver". The policies and policies also stated another preventive intervention listed was to ensure all staff (including front desk, security, housekeeping, environmental services as well as caregivers) received training regarding signs of , tendency to , hazards of elopement, and the importance of prompt reporting, including reporting of incident that occurs during the weekends, nights, or evening. A review of sampled employee's record showed three staff (GG,KK,JJ) did not receive elopement training. A review of the facility's record showed there was no documentation of a preventive plan put in place for residents who resides on the memory care unit (third floor) who eloped on . The facility did not analyze the cause of the incident nor tried access the third floor without an access code from the elevators. This lack of supervision have put thirty other residents who resident on the memory care unit at risk or elopement and put Resident#4 at risk to elope again. During an interview on at 11:17am Director of Memory Care stated no one should be	A 032		

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A 032	Continued From page 22 able to access the third floor without an access code from the elevators. When asked how Resident #4 was able to leave the floor and was found in the valet area of the parking lot, the Director of Memory Care stated she did not know about that incident until she came in at 9AM the day after the event. When asked what was put in place to prevent residents from leaving or eloping from the floor in the future, she stated, "we have changed the code." The Director of Memory Care further stated the resident had eloped by catching an elevator with another resident's private duty aide. During an interview on [redacted] at 2:54pm via phone, the Regional Vice President of the company stated the third floor was a secure unit where residents receives individualized services according to the facility's nurses unlike the residents who are admitted on the other floors. During an interview with Staff X on at 11:30am stated," I was working in the facility for four months and have not received a training on elopement yet. On at 10:45am The Director of Memory Care stated as preventive measure after this elopement, the elevator code to access the third floor was changed. She explained only selective staff such memory care staff, management, and maintenance are the only staff who have the elevator code. 2) A review of the facility's record showed only one elopement drill was conducted in year of 2020. Between to , only one elopement drill was conducted. The only	A 032		

Agency for Health Care Administration

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A 032	Continued From page 23 elopement conducted in year of 2020 was on , the day after Resident#4 eloped. There was no documentation that two annual elopement drills were completed. On at 3:42pm, Regional Vice President stated she would inform management about the issue. Class II	A 032		
A 052 SS=G	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 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	A 052		

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A 052	Continued From page 24 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 prescribed setting of the device. (l) Assisting with measuring vital signs. (m) Assisting with , bags. (4) Assistance with self-administration does not include: (a) Mixing, , converting, or 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 of the body. (d) Administration of preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition.	A 052		

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A 052	Continued From page 25 (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 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be [illegible] 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	A 052		

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A 052	Continued From page 26 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 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	A 052		

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A 052	Continued From page 27 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, and record review, the facility failed to follow the correct procedures when assisting with self-administration of medication for two out of eighteen (Resident #7 and #17) sampled residents. The facility failed to have a license staff administering medication medications to one out of eighteen (Resident #7) sampled residents. Findings included: 1) Observation on at 8:04 AM, revealed that Staff L assisted Resident #17 with her medications. Staff L rubbed sanitizer on her , read orders listed on the medication observation record, removed medication packages from the medication cart and walked to resident's room. The staff read medications labels to the resident and realized she missed one of resident's medications. Then the staff left the room to look for the missing medication leaving all resident's medication packages unlocked, on a chair next to the resident.	A 052		

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A 052	Continued From page 28 Interview conducted on at 8:25 AM, Staff E acknowledged that the staff did not follow the steps in assisting Resident # 17 with medications. 2) Interview conducted on at 4:57 AM, Staff V stated, "are we supposed to give residents the ,?".Staff V stated "They make me help Resident #7 with his , I do not think it is fair. That is not part of my job description." The staff further stated that she was responsible for inserting the resident's suppositories, , 10mg. A review of Resident #7's record showed the resident was diagnosed with , Quad/tetraplegia, and , . The health assessment done on showed the resident was independent with eating, needed supervision with ambulation, and needed assistance with bathing, , grooming, toileting and transferring. The resident was listed as independent with medications. Interview on at 7:00 AM, Staff E stated that Resident #7 took his own medications. She stated that the resident was a paraplegic and he needed assistance with inserting the suppositories. A review of Resident #17's record showed the resident was diagnosed with , Hypertensive, in other classified elsewhere without behavioral disturbance, , following infraction affecting right dominant side. The heath assessment done on showed the resident needed assistance with all activities of daily living. The resident needed assistance with self-administration of medication.	A 052		

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A 052	Continued From page 29 A review of the background database showed Staff V was hired on [redacted] as a Certified Nursing Assistant. A review of the Florida Administrative Code scope of practice description for Certified Nursing Assistants showed that this discipline was "Prohibited from changing sterile [redacted], irrigating body such as giving an , irrigating a [redacted], or mound, performing [redacted] irrigation or feeding, catharizing a patient, administering medications, applying heat by any method, or caring for a tube." A review of the staffing schedule showed Staff V worked in the facility from 11 PM to 7 AM in the Nursing Department. A review of the license verification database showed Staff V was a Certified Nursing Assistant and her license was clear and would expire on [redacted]. Class II	A 052		
A 079 SS=J	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 [redacted] 212 16-25 253	A 079		

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A 079	Continued From page 30 26-35 294 36-45 335 46-55 375 56-65 416 66-75 457 76-85 498 86-95 539 For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week. 2. Independent living residents, as referenced in subsection 59A-36.015(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for 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 [illegible] ( ) 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	A 079		

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A 079	Continued From page 31 medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and . 6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least , must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or manager. 7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the 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.	A 079		

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A 079	Continued From page 32 (c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives. (d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision and care are not being provided to residents, resident care standards described in rule 59A-36.007, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility 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	A 079		

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A 079	Continued From page 33 requirements for the facility and the facility will no longer be required to maintain a plan with the agency. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 59A-36.020, 59A-36.021 or 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review, and interview, the facility failed to provide adequate staff to meet residents scheduled and unscheduled needs. Two residents were left on the floor for several hours after using a pendant or room alarm to call for assistance from staff and received no medical assessment for injury (Residents #1 and 2). Resident #1 suffered a black . , . and other . . Two thousand, two hundred three residents' calls for assistance from 56 of 150 sampled residents over twelve weeks were cancelled after residents received no response in 25 minutes. (Residents #1, 2,3,6,7,8,25,26,27,28,29,30,33,34,35,36,37,38,39 ,40,41,42,44,45,46,47,48,49,50,51,52,53,54,55, 56,57,58,59,60,61,62,63,64,65,66,67,68,69,70,71 ,72,73,74,76,77,and 79). Staff provided no assistance to residents after the calls for help timed out. Findings included: A review of facility records regarding staff	A 079		

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A 079	Continued From page 34 responses to residents' call for assistance showed that 56 of 120 residents did not receive help. 1) Interview on at 2:20 pm with Resident #5 stated, regarding getting assistance from staff, "I am Ok, but when I ring the bell, they take a while to come and when they come, they are upset, like if they don't want to help you." 2) On /2021at 3:30 PM, Resident #2 was observed with a black and blue below the right , and two on the right . In an interview with Resident #2 on at 3:35 PM, the resident stated that she had a bad the previous Thursday ( ) when she was coming out of the bathroom. The resident stated that she called three times and she was told staff would send someone, 'but they never came.' The resident also complained of a strong lower , that was aggravated due to the . The resident ranked the , at 15 from a , scale of 0 to 10 with 0 meaning no , and 10 the worse , possible. A review of the resident's record showed that she had a medical history of lower , and was prescribed , Patch and , ER tablet. A review of the facility's incident report dated at 4:30 PM showed that staff documented "While doing rounds, resident observed on bathroom floor in a sitting position. Resident stated she slipped while coming out the bathroom." A review of the resident record showed no documentation of medical care or follow up to determine the resident's needs for assistance to avoid further . According to the US National Library of Medicine,	A 079		

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A 079	Continued From page 35 " , patches are used to relieve severe , in people who are expected to need , medication around the clock for a long time and who cannot be treated with other medications. , is in a class of medications called opiate ( ) . It works by changing the way the and nervous system respond to , ." According to the US National Library of Medicine, " , is used to relieve moderate to severe , , extended-release tablets and capsules are only used to relieve severe (around-the-clock) , that cannot be controlled by the use of other , medications. , extended-release tablets and capsules should not be used to treat , that can be controlled by medication that is taken as needed. , is in a class of medications called opiate ( ) . It works by changing the way the and nervous system respond to , ." Interviewed on at 9:15 am, Staff D (Licensed Practical Nurse and Floor Supervisor) stated "The facility installed two devices for the residents to notify the staff in case of an emergency. The facility installed a call light in each resident's room except for the third floor." Interview on at 11:00 AM with Resident #18, he stated, "I am ok, but when I ring the bell, they take a while to come and when they come, they were upset, like if they don't want to help you." During a second interview by phone on at 4:45 PM, the resident stated, "When I call, usually is for them to watch me when I go to the bathroom to make sure I don't , otherwise, I move very good with my electric chair."	A 079		

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A 079	Continued From page 36 A review of the pendant and room call light log, which documented when residents pressed an alert when they needed staff assistance, revealed 5,393 calls made by residents between . . . . through . . . . . Further review revealed 2,203 unanswered calls with a response time of "end of chain". When asked what "End of Chain" meant, Staff D stated on . . . . . at 9:17 am that 23 minutes after a resident presses a call light or pendant, the alarm resets automatically if the staff has not responded. She further stated that two minutes later, if there has been no response by 25 minutes from the time of the initial call, the call signal turns itself off. Review of the pendant and room call light log for the period of to for the 2nd, 4th, 5th, 6th, 7th, and 8th floors, room call lights and Pendant alarms, showed the following calls were not responded to included: For the 2nd Floor-371 calls made; 191 calls were not answered in more than 25:04 minutes (End of chain).Explain the end of chain again- These This equals to 51% of calls during this period. For the 4th Floor-1450 calls were made; 862 calls were not answered in more than 25:04 minutes (End of Chain). This equals 59% of calls during this period. For the 5th Floor-1701 calls were made; 790 calls were not answered in more than 23:04 minutes (End of Chain). This equals 46% of calls during this period. For the 6th Floor-1349 calls were made; 193 calls were not answered in more than 23:04 minutes (End of Chain). This equals 14% of calls during this period. For the 7th Floor-398 calls were made; 122 calls were not answered in more than 23:04 minutes	A 079		

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A 079	Continued From page 37 (End of Chain). This equals 31% of calls during this period. For the 8th Floor-127 calls were made; 43 calls were not answered in more than 23:04 minutes (End of Chain). This equals 34% of calls during this period. Further review of facility records found no documentation of staff actions to assist the 56 residents when the 2,203 alarms turned off. Facility record review revealed that Residents #26, 27, 28 and 31 had more than 40 calls for assistance that resulted in an "end of chain" response (no assistance received for at least 25 minutes). A review of the pendant and room call light log showed Resident # 26 had 48 "end of chain" results from his calls for assistance between and . A review of Resident #26's health assessment dated showed the resident had a medical history and diagnoses of ( ), Diastolic and , and . Physical limitation: Needed transfer assistance from one person to go to the bathroom. The resident required assistance with ambulation, bathing, , self- care, toileting, transferring. A review of the pendant and room call light log showed that Resident #27 had 125 "end of chain" results from his calls for assistance between and . A review of Resident #27's health assessment showed the resident had a medical history of Atherosclerotic ,	A 079		

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A 079	Continued From page 38 and . Physical limitation: Uses Walker. The resident required assistance with all activities of daily living. A review of the pendant and room call light log showed that Resident #31 had 201 "end of chain" results from her calls for assistance between and . A review of Resident#31's health assessment dated on showed the resident had medical history and diagnoses of , , , and ( ). Physical limitation: Ambulates with rolling walker. The resident required assistance with bathing and , supervision with eating, grooming, and toileting. A review of the pendant and room call light log showed that Resident #28 had 456 "end of chain" results from her calls for assistance between and . A review of the Resident #28's health assessment showed the resident had medical history and diagnoses of , , , , ( ), and . The resident required assistance with ambulation, bathing, , grooming, toileting and transferring. On At 05:02 AM Staff PP (CNA) stated, "I am the only employee working on the 5th floor and there are 20 residents now. I work as a certified nursing assistant (CNA) from 11:00pm to 7:30 am. When someone is off, the Wellness Director splits the work between us. Like yesterday, I had these same 20 residents and some additional residents from the 4th floor. I give them a shower and I usually start at 6 AM so	A 079		

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A 079	Continued From page 39 I can finish. If I need a break, I would ask the girl from the eighth floor and if she is not busy, she would cover for me. It'soverwhelming. They want you to do everything for $10.00 per hour." In an interview with Resident #1's brother/Power of Attorney (POA) on [redacted] at 12:58 PM, the POA stated the resident had numerous times, and had complained of not getting help before. He further stated that the family installed a camera in Resident #1's bedroom. He stated that during the , , , while observing the resident via the camera, he observed Resident #1 on the floor. He called the facility to inform the staff that Resident #1 had , however no one answered the phone. He stated, he continued to watch the camara to see if someone would come to assist the resident. He said Resident #1 stayed on the floor and did not receive assistance from off the floor until four hours later from a staff on the next shift. The family member stated that he did not recall the exact date or time of the incidents. Further review of facility records showed that Resident #1 had also on and due to , , received an , on [redacted]. Review of the staffing schedule for the night and morning shifts showed 34 staff members provided care to the residents. Observations on at 4:00 AM during the overnight shift (11pm-7pm), showed there were only 6 staff on duty, including CNA (Certified Nursing Assistants) and Medication Technicians ('Med Techs'). Observations on at 4:00 AM found one staff was assigned to each floor on the 2nd, 5th, 6th, 7th, and 8th floors. Further record review and observation showed that no staff were assigned to the fourth floor.	A 079		

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A 079	Continued From page 40 On at 05:05 AM: Staff QQ (CNA) stated, "when someone is off, the Director of Nursing (DON) splits the work between us." On at 4:22 am, Staff V (CNA/Med Tech) stated that she and another staff split the work on the fourth floor because no one was assigned there. - On . . . . . at 12:20 PM, Resident #18's family member stated, "They take a long time to come to the room when he calls." Interview on . . . . . at 3:25 PM Staff X (Valet/Driver) stated," Sometimes residents tell me that they call for assistance and no one comes, so I report it to the front desk. The thing with the staff is, that sometimes you don't see them, you don't know in what room they are." On at 3:30pm Regional Vice President stated, "15 minutes would not be the appropriate time during an emergency. The ideal time would be 4 minutes. But I would have to talk to the Director of Compliance about the action." Class I	A 079		
A 081 SS=D	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service 429.52(1) (1)Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee	A 081		

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A 081	Continued From page 41 provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee's personnel record. (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility	A 081		

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A 081	Continued From page 42 administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident , neglect, and , . The facility must use its prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training	A 081		

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A 081	Continued From page 43 within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to provide in-service training for elopement response; reporting major incidents; resident rights in an assisted living facility; recognizing and reporting resident . . . . . , neglect, and , to facility staff within thirty (30) days of employment for five out of 14 sampled staff (Staff J, GG, II, JJ, and MM). Findings included: A review of Staff J's personnel record showed no documentation of facility's in-service training's for resident rights, , neglect and , , or	A 081		

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A 081	Continued From page 44 reporting adverse incidents. A review of Staff GG' s personnel record showed that the staff was hired on . There was no documentation of facility's in-service training for , neglect and , training. Staff II hired on showed no documentation of facility's in-service training for reporting adverse incidents. Staff JJ hired on showed no documentation of facility's in-service training for resident rights, , neglect and , training, or reporting adverse incidents. Staff MM hired showed no documentation of facility's in-service training for , neglect and , training, or elopement training. On at 3:42 PM the Regional Vice President stated she would inform the Director of compliance about the missing trainings. Class III	A 081		
A 152 SS=D	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.	A 152		

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A 152	Continued From page 45 (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 to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, 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. (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 and interview, the facility failed to provide a clean and safe living environment free of hazards. The facility also failed to ensure the call light systems were working properly. Findings included: Observation on at 7:15 AM during a facility tour showed:	A 152		

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A 152	Continued From page 46 -the wall paint was peeling in # . - roaches on the floor in the bedroom by the closet in # . -the bedroom's light did not work in # . -three filled with next to resident's bed in # -stains on carpet in # # . -the bedrooms were unkept, there were clothes on the furniture and on the floors around the room in #, # . -the closet doors were missing in # , # , # -a strong odor resembling in # . -unlocked cleaning supplies (Detergent and Clorox) in # , # . Interview conducted on at 3:45 PM, Resident's #21 private aide stated the roaches have being an issue for a while, they came and sprayed but the roaches come . Observation on at approximately 5:00 AM showed that on the second floor and third floor the call light in the common bathroom areas were not working. Interview conducted on at 5:03 PM, Staff A stated the facility would send the Maintenance log. Interview conducted on at 5:04 AM, Staff Z stated, "The residents pull them and break them all the time." A review of records received from the facility from through revealed that the maintenance log was not received it. Class III	A 152		

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A 163 SS=D	429.49 FS Records - Resident, Penalties for Alteration (1) Any person who fraudulently alters, defaces, or falsifies any medical or other record of an assisted living facility, or causes or procures any such offense to be committed, commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083. (2) A conviction under subsection (1) is also grounds for restriction, suspension, or termination of license privileges. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility falsified the medical record for one out of 18 sample residents. (Resident #3). Finding include: A review of the facility records documented that Staff FF wrote an incident report at 11:15 PM due Resident #3's . "The resident was found in her room in front of her bed. Staff FF wrote, "reported by C.N.A. while doing rounds. Resident was found on the floor laying on her in front of bed. Observed to be moaning. Denies having any , . 911 was called, Paramedic/Staff was unable to evaluate due to refusal of the resident. Resident observed to be combative. 911 transfer the resident off the floor to her bed. Staff will continue to monitor her". According to the incident form, Staff FF notified the resident's emergency contact on at 1:07 PM. There was no documentation that the resident's Primary Care Provider, Physician A was notified of the incident. A review of Resident #3's observation notes	A 163		

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A 163	Continued From page 48 dated ... at 7:26 AM, showed Staff D wrote " Received report from outgoing lead Med/Tech stating during previous PM shift while C.N.A. was doing her rounds, resident was observed lying flat on her at the bedside. When asked what happened resident stated, "I ". Resident was moaning but denies any . 911 emergency was called. After arrival of EMT resident refused to be evaluated by the EMT staff and became very combative when it was suggested for her to be taken to the hospital for evaluation. Resident was assisted from the floor into her bed. Family notified. Primary doctor notified". A review of Resident #3's Health Assessment showed the resident had medical diagnoses and history of , , , Physical or Sensory Limitation: patient very weak. or Behavioral Status: not applicable. Nursing/Treatment/ , Service Requirement: not applicable. Special Precautions: not applicable. The resident required total care on the following activities of daily living: ambulation, bathing, , self-care (grooming), toileting, and transferring. The resident needed supervision for eating and assistance with self-administration of medications. A review of facility records dated , showed Staff D documented that Physician A was notified on at 11:45 PM and that the resident's emergency contact was notified on at 11:57 PM. In an interview with Physician A's Medical Assistant on at 1:26 PM, the assistant stated that the facility did not notify Physician B	A 163		

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A 163	Continued From page 49 regarding the resident's . on . . . . . The medical assistant also stated that Physician A saw the resident two weeks earlier (on) and no injuries were noted. Class III	A 163		