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
	AL11965313	A. BUILDING: _____ B. WING _____	03/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLISLE PALM BEACH, THE	450 EAST OCEAN AVENUE LANTANA, FL 33462

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced Relicensure, Focused Control and Generator Assessment survey was conducted on through at The Carlisle Palm Beach. The facility had deficiencies at the time of the visit.	A 000		
A 054	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical , the facility must, pursuant to section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the	A 054		

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A 054	Continued From page 1 medication. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure the Medication Observation Records (MORs) were signed immediately after medication assistance was provided to residents for 3 of 5 sampled residents observed during medication pass, Resident # 6, Resident # 10, and Resident # 13. The findings included: On at 3:34 PM , this surveyor requested to review the MORs. Staff D stated she was signing off the medications in the book and was not finished yet. She stated 'you will see a lot of unsigned medications'. An inquiry was made if she was signing off on the MORs immediately after the medications were given to which she gave no response. A random review of the MORs was conducted with Staff D. The review revealed several medications were not signed off by Staff D on the MOR at the time of administration. The following medications were not signed off for the following residents: a) Resident # 6 - Semexion-s 8.6 milligram (mg)-50 mg tab at 9AM - There was no signature in the MORs for and . 2.5 mg tab 9AM - There was no signature in the MORs for . . . and . . . . 10 mg cap 9AM - There was no signature in the MORs for and . , , , 1 mg tab 9AM and 5PM - There was no signature in the MORs for . . . and . . .	A 054		

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A 054	Continued From page 2 . . . . . 325 mg tab 9 AM and 5 PM - There was no signature in the MORs for and . . . . Carvedilil 25 mg tab 9AM and 9 PM - There was no signature in the MORs for and . , 0.5 mg tab 9AM - There was no signature in the MORs for . . . and . . . . b) Resident # 10 - . . . . . 10 mg tab 9AM - There was no signature in the MORs for and . . . . Dr 20 mg tab - There was no signature in the MORs for and . , 20 mg tab 9AM - There was no signature in the MORs for . . . and . . . . 72 mcg cap - There was no signature in the MORs for and . 10 mg tab 9AM and 5PM - There was no signature in the MORs for . . . and . . . . 0.05% . . . . Spray 1 Spray in each nostril twice Daily 9AM and 5PM - There was no signature in the MORs for . . . and . . . . 0.05% . . . Emulsi 9AM and 5PM - There was no signature in the MORs for . and . . . . c) Resident # 13 - . . . . 30 mg tab 9AM - There was no signature in the MORs for . 2.5 mg tab 9AM and 9PM - There was no signature in the MORs for	A 054		

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A 054	Continued From page 3 , 250 mg tab 9AM - There was no signature in the MORs for . , 220 mg tab 9AM and 9PM - There was no signature in the MORs for . During an interview conducted on at 3:36 PM with the Director of Memory Care and the Health and Wellness Director, they acknowledged the findings. Class III	A 054		
A 078	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of	A 078		

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A 078	Continued From page 4 2. If any staff member has, or is suspected of having, a communicable , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable . (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S.	A 078		

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A 078	Continued From page 5 This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure each staff member had evidence of a negative Communicable Status ( ) examination documented on an annual basis for 2 of 4 sampled staff employee records reviewed, Staff A and Staff B. The findings included: a) Review of the employee record for Staff A revealed a hire date of as a medication technician for the 7AM - 3PM shift. Further review revealed no evidence of the Medical Statement of being free of Communicable including . b) Review of the employee record for Staff B revealed a hire date as a Certified Nursing Assistant for the 3 PM - 11 PM shift. Further review revealed no evidence of the Medical Statement of being free of Communicable including . During an interview conducted on at 3:36 PM with the Director of Memory Care and the Health and Wellness Director, they acknowledged the findings and no further information was forthcoming. Class III	A 078		
A 162	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name,	A 162		

Agency for Health Care Administration

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A 162	Continued From page 6 2. , 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance , 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the health care provider and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 described in rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, , or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(e), F.A.C. (f) A record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their recorded semi-annually. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract.	A 162		

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A 162	Continued From page 7 (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to rule 59A-36.008, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in section 429.27, F.S. (l) If the resident is an [illegible] recipient, a copy of the Department of Children and Families form Alternate Care Certification for [illegible], CF-ES 1006, [illegible], which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No =Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the [illegible] of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in rule 59A-36.006, F.A.C.	A 162		

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A 162	Continued From page 8 (o) The resident's . . . . . , DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to the following at the discretion of the facility: 1. A log listing the names of residents participating in this arrangement, 2. The resident demographic data required in this paragraph, 3. The health assessment described in rule 59A-36.006, F.A.C., 4. The resident's contract described in rule 59A-36.018, F.A.C.; and, 5. A health care provider's order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on interview and record review the facility failed to maintain a comprehensive clinical record	A 162		

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A 162	Continued From page 9 for 1 of 4 sampled residents, Resident #7, as evidenced by failing to conduct an initial health assessment in a timely manner; failing to ensure the 1823 Health Assessment reflected the services being provided; and failing to conduct biannual ˘ assessments for Resident #7. The findings included: Review of the clinical record for Resident #7 revealed an admission date of . . . . . with diagnoses to include , ,, and . . . . . Further review of the clinical record revealed the initial 1823 Health Assessment was dated . . . . . with a follow up assessment dated indicating the initial examination was not conducted within 30 days after admission to the facility in 2015. Resident #7 resides in the Memory Care Unit of the facility, her ˘ status is and she requires supervision assistance for all activities of daily living. Further review of the clinical record revealed a Physician Order dated . . . . . for (˘ monitoring). Resident #7 is receiving . . . . . care by facility nursing staff. Review of the Medication Observation Records revealed nursing staff are signing off the monitoring at 7:30 AM and 4:30 PM. Review of the 1823 Health Assessment dated failed to be updated to include . . . . . services and . . . . ˘ monitoring under Nursing/Treatment/ . . . ,, Service Requirements. Additionally, review of the ˘ Record for Resident #7 revealed no ˘ assessments documented for the year 2020. As a result, any	A 162		

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A 162	Continued From page 10 loss or gain could not be determined. During an interview conducted on at 3:36 PM with the Director of Memory Care and the Health and Wellness Director, they acknowledged the findings and no additional information was provided. Class III	A 162		
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 management agency, county health department, or Department of Health. (2) An entity subject to this part may temporarily	CZ830		

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CZ830	Continued From page 11	CZ830		

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 necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be

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CZ830	Continued From page 12 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 submit and have approval of an annual Comprehensive Emergency Management Preparedness (CEMP) plan from the local County Emergency Management Division. The facility's last approved CEMP was on with an expiration date of . The findings included: The facility is a multi-story building with a capacity of 175 residents and a current census of 101 residents as of . During an interview conducted with the Director of Plant Operations on at 1:00 PM, to complete the Generator Assessment, he stated the facility is currently working on their CEMP. A request was made to review the facility's last approval letter. The facility could not provide the	CZ830		

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CZ830	Continued From page 13 last CEMP approval letter, however, the facility provided a letter dated from the local County Emergency Management Division which stated the facility's plan cannot be approved. The crosswalk was attached to this letter which was sent to the facility, high lighting the identified areas requiring correction. Further, the Director of Plant Operations stated he has been working on the plan since he has been employed at the facility, which he stated was over one year. During the Generator Assessment with the Director of Plant Operations on at 1:00 PM, he did not know anything about Monoxide and why it is necessary to have monoxide detectors. A brochure was provided to him to review. He was not present for the remainder of the survey. During a telephone interview conducted with the Senior Planner of the local County Emergency Management Division on at 2:40 PM, he stated the facility's last approved plan is dated , and was valid until . He further stated the facility submitted the plan 8 times which were all rejected. The Senior Planner of the local County Emergency Management Division, forwarded documentation demonstrating the following: The last submission was received on and rejected on . The facility did not provide a crosswalk until they were called and a request made for it. The crosswalk did not identify the deficiencies the facility addressed. The corrections received did not address any prior deficiencies from the last review. The facility has made eight submissions since it's 2013 approval and has been rejected each time. Currently, the facility's CEMP has a total of 15 remaining areas	CZ830		

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
	AL11965313	A. BUILDING: _____ B. WING _____	03/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLISLE PALM BEACH, THE	450 EAST OCEAN AVENUE LANTANA, FL 33462

(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
CZ830	Continued From page 14 that are not in compliance as of . . . . . . A request was made to have the facility Executive Director attend the exit conference on at 3:00 PM to discuss the findings of the CEMP expiration from 2014 and the facility's plan to correct it. The Executive Director expressed disapproval of the local County Emergency Management Division rejections of their corrections to the CEMP. He further stated he has the emergency plan. It was explained that over the 3 days of survey (. . - . . . . .) requests were made to the Associate Executive Director and Director of Plant Operation to review their plan. It was never provided. Due to the repeated rejections, the facility is now required to initiate a new plan. The facility did not provide the new plan for review. The local county Emergency Management Division clearly high lights what corrections are required. During a telephone interview with the Senior Planner of the local County Emergency Management Division on . . . . . at 2:30 PM, he stated they offered to meet with the facility to assist in correcting the deficiencies in their CEMP. This information was related to the Associate Executive Director who was advised to follow up with the local county. Unclassified	CZ830		