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
	AL11910115	A. BUILDING: _____ B. WING _____	04/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADE	160 ISLANDER COURT LONGWOOD, FL 32750

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A 000	Initial Comments The re-licensure survey, an control monitoring and generator monitoring were conducted at Cascade on . The facility had deficiencies at the time of the survey.	A 000		
A 025 SS=D	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 resident diets in accordance with rule	A 025		

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A 025	Continued From page 1 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 observations, record reviews and interviews, the facility failed to follow a health care provider's (HCP) medication order for 1 of 2 sampled residents who received assistance with self-administered medications (#9). Findings: Observations made during a medication pass for resident #9 at 11:15 a.m. on revealed that nurse E sanitized her then she unlocked the med cart. She removed medication packages from the cart and after visually comparing each prescription label to the Medication Administration Record (MAR,) she popped each medication into	A 025		

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A 025	Continued From page 2 a cup. She placed the packages into the cart then she locked it. She took the cup of medications to the resident, who was in her room. The nurse handed the resident the cup of medications, who took them one by one and without help. The nurse observed the resident take the meds then she returned to the medication cart and signed the MAR. Following the medication pass, a comparison of each prescription label to the electronic MAR revealed the directions on the label for were to give 2.5 milligrams (mg) by twice a day and the MAR directions were to give 5 mg twice a day. At 11:28 a.m. on nurse E confirmed the finding and said she did not know why there was a discrepancy. She removed an alert label from the medication cart and placed it on the med package. She walked behind the nurse's station, spoke briefly with the resident care director (RCD) then returned and said the order was for 5 mg twice a day then said she would give the resident another 2.5 mg tablet to equal 5 mg. At 11:32 a.m. on nurse E was seen pouring another 2.5 mg tablet into a medication cup. She then took the cup to the resident in the activity room. She told the resident that she was giving another tablet because the order was for 5 mg, and not 2.5 mg. At 12:15 p.m. on the resident care director (RCD) provided a health care provider's (HCP) order that was dated and that indicated the directions were to give 2.5 mg twice a day for . She said she obtained the order from the pharmacy.	A 025		

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A 025	Continued From page 3 Review of resident #9's current 1823 form that was dated revealed the resident required assistance with self-administration of medications. Further review of the resident's record revealed it did not contain an order from an HCP that was dated after the order. Therefore, the HCP's order was not followed when nurse E gave the resident the extra dose of 2.5 mg. Class III	A 025		
A 032 SS=D	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	A 032		

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A 032	Continued From page 4 pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to sections 429.41(1)(a)3. and 429.41(1)(i), F.S. This Statute or Rule is not met as evidenced by: Based on elopement drills review and interviews,	A 032		

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A 032	Continued From page 5 the facility failed to ensure all direct care staff participated in the facility's elopement drills yearly. Findings: On at 11 AM, staff B, a caregiver said she had not participated in a facility resident elopement drill. Review of staff B's personnel record revealed a hire date of . Review of the facility's documented elopement drills for 2020 and 2021 revealed there was no documentation to confirm that staff B had participated yearly in the facility's elopement drills. On at 1 PM, the administrator was given the opportunity to provide evidence that staff B had participated in the facility's yearly elopement drill and the documentation was not provided. Class III	A 032		
A 054 SS=D	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of	A 054		

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A 054	Continued From page 6 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 medication. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the Medication Administration Record (MAR) for 1 of 2 sampled residents was properly updated (#9). Findings: Review of resident #9's current 1823 form that was dated revealed it indicated the resident required assistance with self-administration of medications. Review of the resident's , MAR revealed an entry for , 5 mg by twice a day. However, review of a HCP's order that was dated revealed the order was to give 2.5 mg twice a day. Further review of the resident's record revealed it did not contain an , order from an HCP that was dated after the	A 054		

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A 054	Continued From page 7 order. Therefore, the entry on the MAR was incorrect. (photographic evidence obtained.) At 12:15 p.m. on the RCD confirmed the findings. Class III	A 054		
A 091 SS=B	59A-36.011(12) FAC Training - Documentation & Monitoring (12) TRAINING DOCUMENTATION AND MONITORING. (a) Except as otherwise noted, certificates, or copies of certificates, of any training required by this rule must be documented in the facility's personnel files. The documentation must include the following: 1. The title of the training program, 2. The subject matter of the training program, 3. The training program agenda, 4. The number of hours of the training program, 5. The trainee's name, dates of participation, and location of the training program, 6. The training provider's name, dated signature and credentials, and professional license number, if applicable. (b) Upon successful completion of training pursuant to this rule, the training provider must issue a certificate to the trainee as specified in this rule. (c) The facility must provide the Department of Elder Affairs and the Agency for Health Care Administration with training documentation and training certificates for review, as requested. The department and agency reserve the right to attend and monitor all facility in-service training, which is intended to meet regulatory requirements.	A 091		

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A 091	Continued From page 8 This Statute or Rule is not met as evidenced by: Based on personnel record review and interview the facility failed to ensure staff had certificates that included the required information for 2 of 4 sampled staff (B and C). Findings: Personnel record review for staff B, a caregiver hired on . . . . . and staff C, a caregiver hired revealed there were certificates in both records for . . . . , neglect and . . . . . and resident rights, control, universal precaution and sanitation procedures and major, adverse incidents and emergency procedures all facility specific, that did not have the number of hours of the training programs listed on the certificate as required. On . . . . . at 12:45 PM, the business office manager confirmed the findings. Class	A 091		