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
	AL11965374	A. BUILDING: _____ B. WING _____	06/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OPALS AT NAPLES	1155 ENCORE WAY NAPLES, FL 34110

(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 control focused visit, emergency power plan monitoring and complaint survey for complaint #2020010235 was conducted on through at The Opals of Naples, an assisted living facility in Naples, Florida. Complaint #2020010235 was substantiated at A0025, A0030, A0053, and A0056. The following is description of the deficiencies. .	A 000		
A 025	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility must notify a licensed physician when a resident exhibits signs of 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 shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition. 59A-36.007 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with rule 59A-36.012, F.A.C.	A 025		

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A 025	Continued From page 1 (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to ensure adequate supervision of [redacted] memory care residents in their living quarters and outside due to less than adequate staff to meet the needs of the population. The facility also failed to provide oversite and monitoring of medication given or not given to residents who are not able to monitor it themselves. The facility was unable to meet the needs for 11 (Residents #1, #2, #5, #6, #8, #9, #10, #11, #12, #13, and #14) of 14 residents observed and reviewed in the facility. Failure to provide adequate supervision lead to resident injuries. It also has the potential for unattended memory care residents outside in the sun for long periods of time.	A 025		

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A 025	Continued From page 2 The findings included: Record review of Resident #1's medication administration record for the month of [redacted], showed the resident did not received his [redacted] medication 20 days out of 28 days. This medication was scheduled to be given at 6 a.m. in the morning. Resident #1 also did not receive [redacted], DR (medication to reduce [redacted]) for 20 days out of 28 days this medication was scheduled to be given. The record showed that Resident #1 had a diagnosis of [redacted] and [redacted]'s [redacted]. Resident #1 had a history and had [redacted] twice in front of the surveyor. The medication for his [redacted]'s helps his [redacted] to move more freely and he is not so stiff Resident #1 is documented as a [redacted] risk and the progress notes for the last 3 months show he has [redacted] several times. On [redacted] Progress notes document that resident has bump/ [redacted] and small [redacted] of unknown origin under left [redacted] with no explanation on how it happened. On [redacted] at 11:16 a.m., Resident #1 was observed in the grass outside close to the front gate no notation of how long he had been out in the elements. On [redacted] at 1:41 p.m., the surveyor entered cottage #1, no staff members were present. There were five residents in the living room area, two men on the couch, one in a chair and a woman pacing [redacted] and forth. Another resident was observed on the floor with his shirt off and	A 025		

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A 025	Continued From page 3 his shorts pulled down around his [illegible] below his [illegible]. The resident appeared to have [illegible] to the floor landing on his [illegible]. The woman came to the surveyor and stated, we need help. Can you help him? The surveyor looked for staff and could not find any. The female resident said, "find some help call someone, no one is here." With that the surveyor approached the man on the floor who was trying to stand to his [illegible] again but was still tangled in his shorts. He then stood up, took a few steps and [illegible] again to his [illegible]. The surveyor intervened and went to the cottage phone and called the front desk, asking the person who answered to send someone to cottage #11 because a resident was on the floor and had [illegible] twice in their presence. Within two minutes the Director of Wellness had arrived at the cottage to care for the resident who had [illegible]. On [illegible] at 8:38 a.m., in an interview with Staff C, she said on [illegible] Resident #2 was left outside on the covered porch of cottage #2 during a thunderstorm. The storm was described by Staff C as being a severe storm and no resident should be left outside. Resident #2 is a [illegible] male with a history of [illegible] with agitation, and [illegible]. Record review of Resident #5's medical record revealed he is an [illegible] male who was admitted to the facility on [illegible] with the following diagnosis: [illegible] with severe agitation, [illegible], and [illegible]. Review of progress notes revealed the resident was noted to have almost daily outbursts of agitation and aggression towards staff. Resident #5 was noted to be up a lot at night and often is noted to be out in the yard area pacing in the middle of the night. Resident	A 025		

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A	Continued From page 4 #5 was noted to be going in and out of other residents' rooms and was found one night to be in a nearby cottage with a woman resident, touching her inappropriately. Documentation showed Resident #5 had injured himself while outside, sustaining cuts and to his . . ., . . ., and . . . Resident #5 is a . . risk and has . . . many times. The chart also revealed the resident has gotten in altercation with other resident and sustained 3 in the month of , from another resident. On Resident #5 was very agitated and blocked 2 caregivers and other residents in a bathroom by a chair. Resident #5's Power of Attorney (POA) was documented as being very concerned the staff are not monitoring Resident #5 close enough and the staff replied to the POA that Resident #5 is very busy walking everywhere, all day long and staff are unable to watch him constantly. She told the POA the only way to have constant supervision is to hire a private duty. The POA is concerned the resident is always getting hurt. Resident #5 was documented as going to the hospital for with injuries multiple times in the last 3 months. On . . . . . at 8:38 a.m., in an interview with Staff C, she stated on Sunday . Resident #5 was left outside for two hours in the sun. She said he walks around in the open area and often goes to the gate and hangs on it to look over it. He does not realize he needs to get out of the sun. Staff C said there are no staff assisting him because when they tried, he would become combative. She said she tried to keep an . . on him and finally was able to convince another staff member and a person in the office to try to get him into the cottage. Once in the cottage the staff	A 025		

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A 025	Continued From page 5 tried to give him a drink of water and put a cool cloth on his . She said she did not know if they had checked him for sunburn or not. Staff C said the facility had no process in place to make sure they know where their residents are at any given time. She also reports on , a resident, Resident #5, was left outside on the porch of cottage #3 after breakfast around 9:00 a.m. until he was found at 2:15 p.m. His caregiver was asked if he had lunch and the caregiver responded he had not because he was combative and she couldn't get him to come inside. The caregiver was told to get him and bring him in at that time, which she did, and he was compliant. He was fed but his adult brief wasn't changed. He was saturated full of and movement. The caregiver said she didn't have anyone to help her change him. Staff C reports she talked with the Administrator of the facility about each one of these issues. On at 8:40 a.m., Staff C said on Resident #6 was seen walking in the outdoor yard between cottage #3 and #4. He was seen bending over to pick something up when he seemed to lose his balance and let himself down to the ground. Staff C said he is a risk. She said she helped him up but was concerned, if she had not seen him he might have been left there. She said during the shifts the caregivers don't look for residents who may not be inside the cottage. Review of Resident #6's record showed the resident as an male with a diagnosis of , behavioral disturbances and . Progress notes recorded Resident #6 has had several and injuries of unknown origin at his right , with a large yellow on	A 025		

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A 025	Continued From page 6 the front of his . . . . . and . . . . on . . . . . . Resident #6 was found on the ground outside. He appeared to be asleep under a tree at 3:45 p.m. In an interview with Staff A on . . . . . at 8:47 a.m., she said she was responsible for getting them all washed, dressed and to the dining room for breakfast. She also said she had to give medications, serve the breakfast, and do the dishes afterwards. She said she was responsible for giving all the medications in her cottage and in cottage #2. She said she had to do all the toileting of the . . . . . residents and give showers also. She said there was no one to cover her cottage when she had to go to cottage #2 to give the medications. She said she feels there is not enough staff to adequately watch over the memory care residents. She said the residents often go outside many times a day. She will be taking care of someone in a room and will not be able to monitor who went out or in. She says when she gives the residents showers it takes her at least 15 minutes and no one is watching the rest of the house. She feels the residents are not watched over well because there is not enough staff to do the job. She said she is very troubled by this because she knows the residents go outside in the hot weather, and there is just no way she can watch them outside too. On at 8:57 a.m., in an interview with Staff B, she said there is no monitoring of residents who are outdoors, and she does not know who is out or for how long they have been outdoors. On . . . . . at 9:22 a.m., in an interview with Caregiver Staff D, she said the caregivers have to get all the residents up, which there are nine residents in cottage three. She says they also	A 025		

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A 025	Continued From page 7	A 025		

have to prepare and serve the meals, breakfast and lunch. They have to change residents who are totally . She has to monitor the other residents that do walk, has to do laundry and showers also. She has to do the dishes. She said there is no way she can monitor the outside and the residents that are walking around out there. She says most of her residents in cottage #3 do not go outside but the residents from cottage #4 often use cottage #3's porch.

On at 11:20 a.m., in interview with licensed practical nurse (LPN) Staff F, she said she was unaware of any policy or procedure for monitoring the residents that were allowed to go outside in the courtyard area that was fenced in-between the cottages. She was never told upon hire of any procedure for keeping track of how long they were out or if they were being regularly, she said she did not know of the incidences that were brought in the complaint. She said she did not feel there were enough caregiver staff to do the job that they were required to do.

In the month of , Resident #8 received 19 doses of from a med tech. Resident #8 also missed 2 doses of his medication.
In the month of , the resident received 10 doses of two different types of from a med tech. Resident #8 also missed 3 doses of the medication.
In the month of , Resident #8 did not get his checked for 4 days in a row, from , , , , , , 16, 17, 18 and , -25. No explanation was found as to why it was not done. The resident also received 6 doses of his for the med tech and missed 3 doses of .

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A 025	Continued From page 8 On at 8:47 a.m., in an interview with Med Tech/Caregiver Staff A, she said she was the only one scheduled in the cottage. Staff A also said a resident lived there a while ago that had . . She said they were having to give the because there was no nurse to do it. She said she is a med tech and that is not in her job. She said she would call off if she knew there wasn't a nurse, because she felt it was dangerous to give the . . from the . . , . . On . . . . . at 6:06 a.m., in an interview with Staff I, she said she is very worried about a lot of the residents not getting their medication in the morning. Staff I said she had to give the to the resident in the early morning before breakfast because there was no nurse on duty. She said it is not supposed to be that way. She said a lot of the med techs are upset about it and do not think they should have to do it. On . . . . . at 2:21 p.m., in an interview with the Wellness Director, she said she was unaware that the med techs were giving the . . to the resident that used to reside in Cottage #1. She said that was only to be done by a nurse. She was aware the was scheduled to be given before breakfast. She could not produce a policy for med techs and their job duties. On review of Resident #9's medical record it revealed the resident was ordered a . . . , patch that is given for , . Resident #9 was to receive this patch once ever 72 hours. It was to stay on until the next patch was due and the old patch would be removed when the new one was placed. On review of the . . . . MOR, Resident #9 did not receive her . , patch from .	A 025		

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A 025	Continued From page 9	A 025		

She had a patch placed on but did not receive another patch until . She did not have a patch placed until . Resident #9 had 4 patches placed in 26 days. Doctor's order was for Resident #9 to receive one patch placed every 3 days which would have been 9 patches.
Resident #9 has .
Resident #9's record documents a diagnosis of and limited functional mobility.
On at 2:20 p.m., LPN Staff F acknowledged from the record, Resident #9 had not been receiving her patch as ordered and there was no explanation in the record as to why.

Review of Resident #10's MOR showed that the resident did not received her noon medication on with no explanation as to why.

Review of Resident #11's MOR showed that Resident #11 did not received his of at 6:00 a.m., once on but his medication card that was filled on showed medication remaining un-dispensed for the dates of , , , , , , , and .
The MOR was signed off as being given by staff.
This resident has a diagnosis of and in which this medication is used for.

On review of the medical record Resident #12 was documented as having the following diagnosis: , , , & low . Resident #12 was prescribed a medication and an , medication. Review of the MOR it was noted the resident did not receive his medications on , , , , , , , , , and .

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A 025	Continued From page 10 On review of the resident controlled substance continual inventory form it was noted there were 3 doses of his 0.5 (milligrams) mg were missing and unaccounted for. On at 2:12 p.m., in an interview with Director of Wellness she said she was unaware of any controlled substance count being off and she had not investigated. The Wellness Director also said she had changed the times of the resident's medication for 6:00 a.m. to 7:00 a.m. to better help staff be able to give the medications. It was noted that each of the medications that were ordered 3 times a day were changed without a doctor's order. On review of Resident #13's MOR it was noted the resident did not receive his once on at 6:00 a.m. On review of the resident's medication card for medication that was filled on , it showed the resident did not receive the medication on , , , , , , , , , and . Resident #13 had a diagnosis of , , . The record was signed off as if the medication was given but it was still in the package. On at 6:06 a.m., Med Tech Staff I said they are not giving the medication and she finds this a lot of the times. On at 2:12 p.m., the Wellness Director said she was aware of a problem and that is why she changed the time from 6:00 a.m. to 7:00 a.m., so the day shift staff could give it. When shown the medication card and the signatures signing it off as given, she said she was unaware. She said she has not been monitoring the medication records or the staff that gives them. On review of Resident #14's MOR it was noted	A 025		

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A 025	Continued From page 11 the resident did not receive her at 6:00 a.m. on and . She also did not receive the same medication at 7:00 a.m. on . Observation of her medication card showed the following days of medication were still in the card and not dispensed: , , , and . Each of these dates were signed off by staff as being given. Resident #14 has a diagnosis of Class II .	A 025		
A 030	59A-36.007(6) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (6) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to rule 59A-36.006, F.A.C. (b) In accordance with section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program,	A 030		

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A 030	Continued From page 12	A 030		

1(888)831-0404; . . . . , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- . . . . . or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font.
(d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding:
1. Resident responsibilities;
2. and tobacco use;
3. Medication storage;
4. Resident elopement;
5. Reporting resident . . . . . , neglect, and , ;
6. Administrative and housekeeping schedules and requirements;
7. . . . . control, sanitation, and universal precautions; and,
8. The requirements for coordinating the delivery of services to residents by third party providers.
(e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws.
(f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to section 429.28(1)(d), F.S. The facility must allow unidentified telephone

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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 030	Continued From page 13 calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. (g) In addition to the requirements of section 429.41(1)(k), F.S., the use of physical by a facility on a resident must be reviewed by the resident's physician annually. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance, is not considered a physical . . . . . 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from . . . . . and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall	A 030		

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A 030	Continued From page 14 make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a	A 030		

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A 030	Continued From page 15 facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names	A 030		

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A 030	Continued From page 16 and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to ensure resident rights to a safe environment to meet the their needs for 11 (Residents #1, #2, #5, #6, #8, #9, #10, #11, #12, #13 and #14) of 14 residents	A 030		

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A 030	Continued From page 17 observed and reviewed. Failure to provide adequate supervision lead to resident injuries of known and unknown origin. Failure to provide adequate supervision lead to resident injuries. It also has the potential for unattended memory care residents outside in the sun for long periods of time. The findings included: Record review of Resident #1's medication administration record for the month of , showed the resident did not received his , medication 20 days out of 28 days. This medication was scheduled to be given at 6 a.m. in the morning. Resident #1 also did not receive , DR (medication to reduce) for 20 days out of 28 days this medication was scheduled to be given. The record showed that Resident #1 had a diagnosis of , - , and 's . Resident #1 had a history and had twice in front of the surveyor. The medication for his 's helps his to move more freely and he is not so stiff Resident #1 is documented as a risk and the progress notes for the last 3 months show he has several times. On Progress notes document that resident has bump/ and small of unknown origin under left , with no explanation on how it happened. On at 11:16 a.m., Resident #1 was observed in the grass outside close to the front gate no notation of how long he had been out in the elements.	A 030		

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A 030	Continued From page 18 On at 1:41 p.m., the surveyor entered cottage #1, no staff members were present. There were five residents in the living room area, two men on the couch, one in a chair and a woman pacing and forth. Another resident was observed on the floor with his shirt off and his shorts pulled down around his below his . . . . The resident appeared to have . . to the floor landing on his . The woman came to the surveyor and stated, we need help. Can you help him? The surveyor looked for staff in any of the rooms and could not find any. The female resident said, "find some help call someone, no one is here." With that the surveyor approached the man on the floor who was trying to stand to his again but was still tangled in his shorts. He then stood up, took a few steps and . . again to his . . . . The surveyor intervened and went to the cottage phone and called the front desk, asking the person who answered to send someone to cottage #11 because a resident was on the floor and had twice in their presence. Within two minutes the Director of Wellness had arrived at the cottage to care for the resident who had . On at 8:38 a.m., in an interview with staff C, she said on . . . . . Resident #2 was left outside on the covered porch of cottage #2 during a thunderstorm. The storm was described by Staff C as being a severe storm and no resident should be left outside. Resident #2 is a male with a history of with agitation, and . . . . . . Record review of Resident #5's medical record revealed he is an male who was admitted to the facility on . . . . . with the following diagnosis:	A 030		

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A 030	Continued From page 19 with severe agitation, , and . In review of progress notes, the resident was noted to have almost daily outbursts of agitation and aggression towards staff. Resident #5 is noted to be up a lot at night and often is noted to be out in the yard area pacing in the middle of the night. Resident #5 was noted to be going in and out of other residents' rooms and was found one night to be in a nearby cottage with a woman resident, touching her inappropriately. Documentation showed Resident #5 had injured himself while outside, sustaining cuts and to his , , and . Resident #5 is a risk and has many times. The chart also revealed the resident has gotten in altercation with other resident and sustained 3 in the month of , from another resident. On Resident #5 was very agitated and blocked 2 caregivers and other residents in a bathroom by a chair. Resident #5's Power of Attorney (POA) was documented as being very concerned the staff are not monitoring Resident #5 close enough and the staff replied to the POA that Resident #5 is very busy walking everywhere, all day long and staff are unable to watch him constantly. She told the POA the only way to have constant supervision is to hire a private duty. The POA is concerned the resident is always getting hurt. Resident #5 was documented as going to the hospital for with injuries multiple times in the last 3 months. On at 8:38 a.m., in an interview with Staff C, she stated on Sunday Resident #5 was left outside for two hours in the sun. She said he walks around in the open area and often goes to the gate and hangs on it to look over it.	A 030		

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A 030	Continued From page 20 He does not realize he needs to get out of the sun. Staff C said there are no staff assisting him because when they tried, he would become combative. She said she tried to keep an , on him and finally was able to convince another staff member and a person in the office to try to get him into the cottage. Once in the cottage the staff tried to give him a drink of water and put a cool cloth on his . . . . She said she did not know if they had checked him for sunburn or not. Staff C said the facility had no process in place to make sure they know where their residents are at any given time. She also reports on , a resident, Resident #5, was left outside on the porch of cottage #3 after breakfast around 9:00 a.m. until he was found at 2:15 p.m. His caregiver was asked if he had lunch and the caregiver responded he had not because he was combative and she couldn't get him to come inside. The caregiver was told to get him and bring him in at that time, which she did, and he was compliant. He was fed but his adult brief wasn't changed. He was saturated full of and . . . movement. The caregiver said she didn't have anyone to help her change him. Staff C reports she talked with the Administrator of the facility about each one of these issues. On at 8:40 a.m., Staff C said on Resident #6 was seen walking in the outdoor yard between cottage #3 and #4. He was seen bending over to pick something up when he seemed to lose his balance and let himself down to the ground. Staff C said he is a . risk. She said she helped him up but was concerned, if she had not seen him he might have been left there. She said during the shifts the caregivers don't look for residents who may not be inside the cottage.	A 030		

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A 030	Continued From page 21 Review of Resident #6's record showed the resident as an , male with a diagnosis of [illegible] behavioral disturbances and [illegible]. Progress notes recorded Resident #6 has had several and injuries of unknown origin at his right [illegible], with a large yellow [illegible] on the front of his and on . Resident #6 was found on the ground outside. He appeared to be asleep under a tree at 3:45 p.m. In an interview with Staff A on at 8:47 a.m., she said she was responsible for getting them all washed, dressed and to the dining room for breakfast. She also said she had to give medications, serve the breakfast, and do the dishes afterwards. She said she was responsible for giving all the medications in her cottage and cottage #2. She said she had to do all the toileting of the residents and give showers also. She said there was no one to cover her cottage when she had to go to cottage #2 to give the medications. She said she feels there is not enough staff to adequately watch over the memory care residents. She said often they go outside many times a day. She will be taking care of someone in a room and will not be able to monitor who went out or in. She says when she gives the residents showers it takes her at least 15 minutes and no one is watching the rest of the house. She feels the residents are not watched over well because there is not enough staff to do the job. She said she is very troubled by this because she knows the residents go outside in the hot weather, and there is just no way she can watch them outside too. On at 8:57 a.m., in an interview with Staff B, she said there is no monitoring of residents who are outdoors, and she does not know who is	A 030		

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A 030	Continued From page 22 out or for how long they have been outdoors. On . . . . . at 9:22 a.m., in an interview with Caregiver Staff D, she said the caregivers have to get all the residents up, which there are nine residents in cottage three. She says they also have to prepare and serve the meals, breakfast and lunch. They have to change residents who are totally . . . . . She has to monitor the other residents that do walk, has to do laundry and showers also. She has to do the dishes. She said there is no way she can monitor the outside and the residents that are walking around out there. She says most of her residents in cottage #3 do not go outside but the residents from cottage #4 often use cottage #3's porch. On at 11:20 a.m., in interview with licensed practical nurse (LPN) Staff F, she said she was unaware of any policy or procedure for monitoring the residents that were allowed to go outside in the courtyard area that was fenced in-between the cottages. She was never told upon hire of any procedure for keeping track of how long they were out or if they were being , regularly, she said she did not know of the incidences that were brought in the complaint. She said she did not feel there were enough caregiver staff to do the job that they were required to do. In the month of , Resident #8 received 19 doses of . . from a med tech. Resident #8 also missed 2 doses of his medication. In the month of , the resident received 10 doses of two different types of . . from a med tech. Resident #8 also missed 3 doses of the medication. In the month of , Resident #8 did not	A 030		

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A 030	Continued From page 23 get his [redacted] checked for 4 days in a row, from [redacted], 16, 17, 18 and [redacted]-25. No explanation was found as to why it was not done. The resident also received 6 doses of his [redacted] for the med tech and missed 3 doses of [redacted]. On [redacted] at 8:47 a.m., in an interview with Med Tech/Caregiver Staff A, she said she was the only one scheduled in the cottage. Staff A also said a resident lived there a while ago that had [redacted]. She said they were having to give the [redacted] because there was no nurse to do it. She said she is a med tech and that is not in her job. She said she would call off if she knew there wasn't a nurse, because she felt it was dangerous to give the [redacted] from the [redacted]. On [redacted] at 6:06 a.m., in an interview with Staff I, she said she is very worried about a lot of the residents not getting their medication in the morning. Staff I said she had to give the [redacted] to the resident in the early morning before breakfast because there was no nurse on duty. She said it is not supposed to be that way. She said a lot of the med techs are upset about it and do not think they should have to do it. On [redacted] at 2:21 p.m., in an interview with the Wellness Director, she said she was unaware that the med techs were giving the [redacted] to the resident that used to reside in Cottage #1. She said that was only to be done by a nurse. She was aware the [redacted] was scheduled to be given before breakfast. She could not produce a policy for med techs and their job duties. On review of Resident #9's medical record it revealed the resident was ordered a [redacted] patch that is given for [redacted]. Resident #9	A 030		

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A 030	Continued From page 24 was to receive this patch once every 72 hours. It was to stay on until the next patch was due and the old patch would be removed when the new one was placed. On review of the MOR, Resident #9 did not receive her patch from . She had a patch placed on but did not receive another patch until . She did not have a patch placed until . Resident #9 had 4 patches placed in 26 days. Doctor's order was for Resident #9 to receive one patch placed every 3 days which would have been 9 patches. Resident #9 has . Review of Resident #9's record documents a diagnosis of , and limited functional mobility. On at 2:20 p.m., LPN Staff F acknowledged from the record, Resident #9 had not been receiving her patch as ordered and there was no explanation in the record as to why. Review of Resident #10's MOR showed that the resident did not received her noon medication on with no explanation as to why. Review of Resident #11's MOR showed that Resident #11 did not received his of at 6:00 a.m., once on but his medication card that was filled on showed medication remaining un-dispensed for the dates of , , , , , & . The MOR was signed off as being given by staff. This resident has a diagnosis of and in which this medication is used for. On review of the medical record Resident #12 was documented as having the following	A 030		

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A 030	Continued From page 25 diagnosis: [illegible], & low [illegible]. Resident #12 is prescribed a [illegible] medication and an [illegible] medication. With review of the [illegible] MOR it was noted the resident did not receive his [illegible] medications on [illegible] & [illegible]. On review of the resident controlled substance continual inventory form it was noted there were 3 doses of his 0.5 (milligrams) mg were missing and unaccounted for. On [illegible] at 2:12 p.m., in an interview with Director of Wellness she said she was unaware of any controlled substance count being off and she had not investigated. The Wellness Director also said she had changed the times of the resident's medication for 6:00 a.m. to 7:00 a.m. to better help staff be able to give the medications. It was noted that each of the medications that were ordered 3 times a day were changed without a doctor's order. On review of Resident #13's MOR it was noted the resident did not receive his [illegible] once on [illegible] at 6:00 a.m. On review of the resident's medication card for medication that was filled on [illegible], it showed the resident did not receive the medication on [illegible] & [illegible]. Resident #13 had a diagnosis of [illegible]. The record was signed off as if the medication was given but it was still in the package. On [illegible] at 6:06 a.m., Med Tech Staff I said they are not giving the medication and she finds this a lot of the times. On [illegible] at 2:12 p.m., the Wellness Director said she was aware of a problem and that is why she changed the time from 6:00 a.m. to 7:00 a.m., so the day shift staff could give it. When	A 030		

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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 030	Continued From page 26 shown the medication card and the signatures signing it off as given, she said she was unaware. She said she has not been monitoring the medication records or the staff that gives them. On review of Resident #14's MOR it was noted the resident did not receive her [redacted] at 6:00 a.m. twice on [redacted] and [redacted]. She also did not receive the same medication at 7:00 a.m. on [redacted]. Observation of her medication card showed the following days of medication were still in the card and not dispensed: [redacted], [redacted], [redacted], and [redacted]. Each of these dates were signed off by staff as being given. Resident #14 has a diagnosis of [redacted]. Class II	A 030		
A 053	59A-36.008(4) FAC Medication - Administration (4) MEDICATION ADMINISTRATION. (a) For facilities that provide medication administration, a staff member licensed to administer medications must be available to administer medications in accordance with a health care provider's order or prescription label. (b) Unusual reactions to the medication or a significant change in the resident's health or behavior that may be caused by the medication must be documented in the resident's record and reported immediately to the resident's health care provider. The contact with the health care provider must also be documented in the resident's record. (c) Medication administration includes conducting any examination or other procedure necessary for the proper administration of medication that the resident cannot conduct personally and that can be performed by licensed staff.	A 053		

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	AL11965374	A. BUILDING: _____ B. WING _____	06/28/2020

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A 053	Continued From page 27 (d) A facility that performs clinical laboratory tests for residents, including testing, must be in compliance with the federal Clinical Laboratory Improvement Amendments of 1988 (CLIA) and chapter 483, part I, F.S. A valid copy of the State Clinical Laboratory License, if required, and the federal CLIA Certificate must be maintained in the facility. A state license or federal CLIA certificate is not required if residents perform the test themselves or if a third party assists residents in performing the test. The facility is not required to maintain a State Clinical Laboratory License or a federal CLIA Certificate if facility staff assist residents in performing clinical laboratory testing with the residents' equipment. Information about the State Clinical Laboratory License and federal CLIA Certificate is available from the Laboratory Unit, Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop 32, Tallahassee, FL 32308; telephone (850)412-4500. This Statute or Rule is not met as evidenced by: Based on staff interview and record review the facility failed to administer medication in a safe manor with the proper personnel to 1 (Resident #8) of 1 resident reviewed for administration. The findings included: In the month of , the Resident #8 received 19 doses of from a med tech. Resident #8 also missed 2 doses of his medication. In the month of , the resident received 10 doses of two different types of from a med tech. Resident #8 also missed 3 doses of the medication. In the month of , Resident #8 did not	A 053		

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A 053	Continued From page 28 get their [redacted] checked for 4 days in a row from [redacted], 16, 17, 18 and [redacted]-25. No explanation was found as to why it was not done. The resident also received 6 doses of his [redacted] from the med tech and missed 3 doses of [redacted]. On [redacted] at 8:47 a.m., in an interview with Med Tech/Caregiver Staff A, she said she was the only one scheduled in the cottage. Staff A also said that a resident lived there a while ago that had [redacted]. She said that they were having to give the [redacted] because there was no nurse to do it. She said she is a med tech and that is not in her job. She said she would call off if she knew there wasn't a nurse because she felt that it was dangerous to give the [redacted] from the [redacted]. On [redacted] at 6:06 a.m., in an interview with Staff I, she said she is very worried about a lot of the residents not getting their medication in the morning. She said when the resident who was on [redacted] in the early morning before breakfast, the med tech had to give it because there was not a nurse on duty. She said it is not supposed to be that way. She said a lot of the med techs are upset about it and do not think they should have to do it. On [redacted] at 2:21 p.m., in an interview the Wellness Director said she was unaware that the med techs were giving the [redacted] to the resident that used to reside in cottage #1. She said that was only to be done by a nurse. She was aware the [redacted] was scheduled to be given before breakfast. She could not produce a policy for med techs and their job duties. Class II	A 053		

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A 056	Continued From page 29	A 056		
A 056	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with chapters 465 and 499, F.S., and rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist. (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must	A 056		

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A 056	Continued From page 30 be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record. (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable. (f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner. (g) Pursuant to section 465.0276(5), F.S., and rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following: 1. Practitioner's name, 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and,	A 056		

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A 056	Continued From page 31 6. Expiration date. (h) Pursuant to section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to properly administer medication as ordered by a physician for 8 (Resident #1, #8, #9, #10, #11, #12, #13 and #14) of 14 residents reviewed for medication administration or assistance with self administration of memory care residents. The findings included: On Record review of Resident #1, the medication administration record for the month of [redacted] showed the resident did not received his [redacted] medication 20 out of 28 days. This medication was scheduled to be given at 6:00 a.m. in the morning. Resident #1 did not receive [redacted] DR (medication to reduce [redacted]) for 20 out of 28 days this medication was scheduled to be given. The record showed Resident #1 has a diagnosis of [redacted] and [redacted]'s [redacted], both need the medication listed above that were failed to be given. On closed record review of Resident #8's medication administration record (MAR): In the month of [redacted], Resident #8 missed 2 doses of his [redacted] medication. In the month of [redacted], Resident #8 missed 3	A 056		

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A 056	Continued From page 32 doses of the medication. In the month of , Resident #8 did not get is checked for 4 days in a row from , , , , , , , 16, 17, 18 and , -25. No explanation was found as to why it was not done and Resident #8 also missed 3 doses of . On at 8:47 a.m., in an interview with Med Tech/Caregiver Staff A, she said she was the only one scheduled in the cottage. Staff A also said a resident lived there a while ago that had . She said they were having to give the because there was no nurse to do it. She said she is a med tech and that is not in her job. She said she would call off if she knew there wasn't a nurse, because she felt it was dangerous to give the from the , . On at 6:06 a.m., in an interview with Staff I, she said she is very worried about a lot of the residents not getting their medication in the morning. On at 2:21 p.m., in an interview with the Wellness Director she said that she was unaware that the med techs were giving the to the resident that use to reside in cottage #1. She said that was only to be done by a nurse. She was aware that the was scheduled to be given before breakfast. She could not produce a policy for med techs and their job duties. She was also not aware of the missed doses. Review of Resident #9's medical record revealed the resident was ordered a , patch that is given for . Resident #9 was to receive this patch once every 72 hours. It was to stay on until the next patch was due and the old patch would be removed when the new one was	A 056		

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A 056	Continued From page 33 placed. On review of the [redacted] MOR, Resident #9 did not receive her [redacted] patch from [redacted]. She had a patch placed on [redacted] but did not receive another patch until [redacted]. She did not have a patch placed until [redacted]. Resident #9 had 4 patches placed in 26 days. Doctor's order was for Resident #9 to receive one patch placed every 3 days which would have been 9 patches. Resident #9 has [redacted]. Review of Resident #9's record documents a diagnosis of [redacted] and limited functional mobility. On [redacted] at 2:20 p.m., Licienced Practical Nurse (LPN) Staff F acknowledged from the record that Resident #9 had not been receiving her [redacted] patch as ordered and there was no explanation in the record as to why. Review of Resident #10's [redacted] MAR showed the resident did not received her noon medication on [redacted] with no explanation as to why. Review of Resident #11's [redacted] MAR showed that Resident #11 did not received his of [redacted] at 6:00 a.m., once on [redacted] but his medication card that was filled on [redacted] showed medication remaining un-dispensed for the dates of [redacted] & [redacted]. The MAR was signed off as being given by staff. This resident has a diagnosis of [redacted] and [redacted] in which this medication is used for. On review of the medical record Resident #12 was documented as having the following diagnosis: [redacted], & low [redacted]. Resident #12 is prescribed a	A 056		

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A 056	Continued From page 34 medication and an medication. With review of the MAR it was noted the resident did not receive his medications on & . On review of the resident controlled substance continual inventory form it was noted there were 3 doses of his 0.5 (milligrams) mg were missing and unaccounted for. On at 2:12 p.m., in an interview with Director of Wellness she said she was unaware of any controlled substance count being off and she had not investigated. The Wellness Director also said she had changed the times of the resident's medication for 6:00 a.m. to 7:00 a.m. to better help staff be able to give the medications. It was noted that each of the medications that were ordered 3 times a day were changed without a doctor's order. She said she was not aware that the resident had missed so many doses. On review of Resident #13's medication administration record (MAR) it was noted the resident did not receive his once on at 6:00 a.m. On review of the resident's medication card for medication that was filled on , it showed the resident did not receive the medication on , and . Resident #13 had a diagnosis of . The record was signed off as if the medication was given but it was still in the package. On at 6:06 a.m., Med Tech Staff I said they are not giving the medication and she finds this a lot of the times. On at 2:12 p.m., the Wellness Director said she was aware of a problem and that is why she changed the time from 6:00 a.m. to 7:00 a.m., so the day shift staff could give it. When	A 056		

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A 056	Continued From page 35 shown the medication card and the signatures signing it off as given, she said she was unaware. She said she has not been monitoring the medication records or the staff that gives them. She was also unaware that the resident did not receive the medication as ordered. On review of Resident #14's MAR it was noted the resident did not receive her [illegible] at 6:00 a.m. twice on & . She also did not receive the same medication at 7:00 a.m. on . Observation of her medication card showed the following days of medication were still in the card and not dispensed: - , , , & . Each of these dates were signed off by staff as being given. Resident #14 has a diagnosis of [illegible]. Class II	A 056		