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
	AL11910126	A. BUILDING: _____ B. WING _____	06/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLA OF ALTAMONTE SPRINGS	433 ORANGE DRIVE ALTAMONTE SPRINGS, FL 32701

(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 Complaint Investigation #2021006517 was conducted from [redacted] /2021. Grand Villa Altamonte Springs had deficiencies at the time of the visit.	A 000		
A 025 SS=G	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 [redacted] 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		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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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 provide adequate supervision and failed to provide care and services appropriate to meet the needs to ensure safety through proactive measures to minimize the potential for and injuries for 2 of 12 sampled residents who experienced repeated with injuries (#1 & #2), failed to follow health care provider order to obtain , , , , for 1 of 12 sampled resident (#2), and failed to have documented evidence to indicate were removed for 1 of 12 sampled residents (#9). Findings:	A 025		

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A 025	Continued From page 2 1. Resident #1's record revealed a facility admission date of . Review of the 1823 health assessment forms, dated and , revealed she required supervision with assistance with her activities of daily living (ADLs). Her diagnoses included , Communication , Degenerative of Nervous System, , history of a wedge of first ; she was identified as a risk. On at 10:06 a.m., the resident sat in a wheelchair in the common area of the secured memory care unit. Review of facility notes, and incident reports revealed the following: On at 7:45 p.m., she was sitting on the floor in the doorway of her apartment. She said she lost her balance. Her walker was across the room. She initially in front of her sofa then scooted to the front door. She had shoes on. On at 2 p.m., she was sitting on the floor in her bedroom by the door. She had shoes on, and her walker was behind her by the bed. She said she lost her balance while walking to close the door. On at 4:45 p.m., she was sitting on the floor with her against the sofa. She wore shoes and her walker was not near her. She said she was trying to water a plant in her living room without her walker and her gave out and she to floor. On at 6 p.m., she was sitting on the floor with her against the sofa. She had shoes	A 025		

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A 025	Continued From page 3 on, and her walker was within reach. She said she rolled off the sofa while sleeping. On at 10:30 p.m., she was on the floor in her room in the doorway sitting on her . Her walker was in the bathroom. She wore shoes. On at 4:20 p.m., she was lying on the floor in her bedroom with her facing the bedroom door. Her walker was not within reach. She said she lost her balance and . She was sent to the hospital via 911. On at 1:30 a.m., she returned from the hospital. She had a broken collar bone, and her arm was in a sling. On at 3:45 p.m., she was found on the floor wrapped in her blanket after attempting to walk without her walker from the bed to the sofa. Her family member declined a visit to the emergency room. On at 4:15 p.m., a facility note indicated that when she at 3:45 p.m. she did not have shoes on but wore non-slip socks. On at 3:45 p.m., she was heard yelling for help in her bathroom and she was observed lying on the floor with a bag of briefs under her . She had socks on, and the staff member was unsure if they were non-slip or not. She did not wear shoes and her walker was not within reach. On at 11:45 p.m., she had a . The health care provider was notified and would have a conversation with the resident's family about placing her in a rehab facility.	A 025		

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A 025	Continued From page 4 On at 11:25 a.m., a staff member entered her room and observed the resident lying on the floor in front of her bed. She did not wear shoes but wore non-slip socks. Her walker was not nearby. On , a health care provider ordered a hospital bed. On at 7:35 a.m., a staff member entered her room and found her lying on the living room floor. She wore non-slip socks, and her walker was not nearby. She said she on her in the bathroom then crawled out. She had a on her forehead. She was sent to the hospital via 911. On , she returned from a rehab center. She required assistance with all of her ADLs, reminders to use her walker and to not ambulate unassisted. On at 9:30 a.m., she was being wheeled to visit a room in the 100 building and while going down the ramp outside the front main entrance, the rug rolled up and the resident forward. She sustained an on her right . On at 1:45 p.m., she remained in her room and refused all attempts to get her to come out. Staff did frequent checks and reeducated her to call for help before ambulating. On at 7:45 p.m., a health care provider ordered physical and occupational therapies due to , an unsteady gait, and for wheelchair training. On at 3:30 p.m., a maintenance staff	A 025		

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A 025	Continued From page 5 member went into her room and saw her sitting on the bathroom floor in front of the toilet. She wore non-slip socks; her walker was near the bathroom, and she was unable to say what happened. She sustained a . . . . on her right , . On at 3:45 p.m., she slipped out of bed and onto her . . . . . Her family declined a visit to the hospital. On at 6:30 p.m., she was observed on the floor in her doorway by the housekeeping supervisor at approximately 5 p.m. She said she was walking in her room, lost her balance, then scooted to the door. Her walker was flipped over. She said she could not recall exactly what happened to cause the , but the of her shirt was wet. She wore non-slip socks but the pads on the bottom of them were worn making it easier for her to . . Her family was called and were asked to bring her new socks. At at 10:25 p.m., staff heard her screaming for help. She was observed on the floor in her room. She had a bump on her forehead and . . . . on her arm. She wore socks, no shoes and her walker were nearby. She said she was trying to go to the bathroom. She was sent to the hospital via 911. She was reminded to wear the proper footwear, to have her walker with her, to allow staff to assist her, and her level of care would be checked. At . . . . at 6:15 p.m., she was out of her room more to engage her in activities because she was always in her room, and she continued to . . She was agitated with being out of her room but continued to transfer in her room without proper footwear and without using her walker.	A 025		

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A 025	Continued From page 6 On at 5 p.m., she was brought out to the common areas most of the day and offered activities, but she refused and became upset. The supervisor explained to her that the staff were trying to keep her safe since she did not ask for assistance, continued to , and did not use her assistive devices. She was offered multiple rests throughout the day and toileted, but she refused and continued to request to stay in her room. On , a health care provider ordered , , , ( ), , , ( ), and a wheelchair. On , a health care provider ordered . On at 11:45 p.m., staff heard her yelling for help. She was observed sitting on the floor in her room. She wore non-slip socks, and her walker and wheelchair were not nearby. She said she went to the bathroom then lost her balance when she was leaving the bathroom. On , a evaluation was completed. On at 11 p.m., she was observed sitting on the floor between her bathroom and her bedroom. She wore non-slip socks and neither her walker nor wheelchair were nearby. She was encouraged to allow staff to help her with ADLs. On at 6 a.m., two other residents reported that she was on the floor by the laundry room. She wore non-slip socks, and her walker was nearby. She was reminded to use her wheelchair for longer distances due to her	A 025		

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A 025	Continued From page 7 On , a health care provider ordered a due to multiple . On at 6:55 a.m., staff observed her on the floor by her bathroom. There was on the floor. She wore a non-slip sock on only one . Her walker was near her and her wheelchair was at the of her bed. She sustained a on her forehead and was sent to the hospital via 911. On , a provider's note indicated that she did not have a ( ). On , she returned from the hospital with five on her forehead, a large on her left , and on both . Documentation on an incident investigation form indicated that she had an increase in her level of care and increased need for toileting assistance. She owned only non-slip socks and was encouraged to wear them at all times. On at 7:40 p.m., staff observed her on the floor near the of her bed. Her commode was on the floor by the bed. Her assistive devices were by the bed, and she was not using them. There was on the bathroom door and her . She said she hit her and she was from her . She wore non-slip socks. The sutured on her forehead reopened. She was sent to the hospital via 911. She was reminded to allow staff to help her and to use her assistive devices. On , a provider ordered a hospital bed. The resident's record did not reveal any documentation to indicate the and evaluations that were ordered on were	A 025		

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A 025	Continued From page 8 ever done. On at 10:50 a.m., staff H said to decrease the resident's risk for , he kept her out of her room where she could be seen. On at 10:56 a.m., an attempt was made to interview the resident but she did not maintain contact, and her responses were incoherent. On at 10:58 a.m., staff G said to prevent the resident from falling she kept the resident within eyesight and met the resident's ADL needs. On at 11:01 a.m., staff I said to prevent the resident from falling she told the resident to stay seated and assisted the resident with toileting. On at 12:15 p.m., a hospital bed frame and style bed rails were seen on the resident's bed. On at 12:45 p.m., the findings were discussed with the administrator and the memory care director. An opportunity was given to provide documentation of all interventions implemented by the facility each time the resident . On at 3:15 p.m., the memory care director said she was unable to find any documentation to indicate the and evaluations that were ordered on were ever done. Resident #1 suffered 19 between and , some of which resulted in injuries, including a and . Facility documentation did not indicate adequate supervision and sufficient interventions were	A 025		

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A 025	Continued From page 9 implemented by the facility following each to minimize the potential for further . 2. Resident #9's record revealed a health assessment, dated , with diagnoses that included , Memory , , Restlessness, and Agitation. The facility records revealed on , the resident had a , later had left , surgery, and was admitted to a rehabilitation center. The facility's electronic notes documented that the resident returned on . The memory care director documented on at 1:45 PM, while toileting the resident, she observed two stitches still in place at the left , area. The health care provider was notified. The record did not reveal any documentation about the health care provider's reply regarding the stitches and if the stitches were removed. An order, signed by the health care provider, noted Resident status report - "stitches". Telephone orders/physician orders - "Home health orders to remove stitches left ,." On at 2 PM, the memory care director said she observed the stitches on the resident's left , on . She said the resident was very combative and it may have been difficult for someone to remove the stitches. She said the doctor may have removed them, without notifying the facility. She had searched for documentation of when and who removed the stitches and could not find any. She said she could not find any evidence that the facility followed the health care provider's order for home health to remove the stitches. She confirmed the stitches may have not been removed until after the health care provider's orders were written on , 5	A 025		

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A 025	Continued From page 10 months after surgery. 3. Resident #2's record revealed an admission date of . The most recent health assessment was dated , and included diagnoses of , and . She was noted to be at risk for , required assistance with all ADLs, and used a walker to ambulate. Facility notes and reports for 2021 revealed 8 between and . - unwitnessed , no injury. - witnessed , lost balance in dining room, on treated in facility. - unwitnessed , slid out of recliner, no injuries. ordered, - moved to memory care, unwitnessed at 1:00 PM, on , treat in facility. A second unwitnessed at 7:15 PM. Staff attempt to left resident off floor, resident unable to bear , 911 called, sent to emergency department (ED). Returned to facility on , no - unwitnessed , found on floor next to bed, no footwear. Second order for . - witnessed , wearing proper footwear, caught on of chair, lost balance. No injuries. - unwitnessed . Observed sitting in lobby with over right and in of right . 911 called, sent to ED. Returned same day with 3 on right . Review of notes revealed had not been started as of . On at 9:45 AM, the memory care director confirmed there was an order for , dated , but did not know why it was not started	A 025		

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A 025	Continued From page 11 at that time. She confirmed the second order for on was refused by the resident's son at first due to financial concerns, but then agreed when he was assured it was covered. The memory care director stated the request was sent to one agency on but was denied due to the resident's insurance plan. The request was sent to a second agency on , but had still not started as of . She contacted the home health agency who said they would come on . On at 4:30 PM, the regional nurse stated the home health agency nurse appeared to have signed into the facility to see the resident to open the case record but did not leave any documentation or speak with any staff member about the visit or plans for , Class II	A 025		
A 030 SS=D	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	A 030		

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A 030	Continued From page 12	A 030		

to demonstrate that such procedure is implemented upon receipt of a complaint.
(c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font.
(d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding:
1. Resident responsibilities;
2. and tobacco use;
3. Medication storage;
4. Resident elopement;
5. Reporting resident , neglect, and ;
6. Administrative and housekeeping schedules and requirements;
7. control, sanitation, and universal precautions; and,
8. The requirements for coordinating the delivery of services to residents by third party providers.
(e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the

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A 030	Continued From page 13	A 030		

facility, the resident must be compensated in compliance with state and federal wage laws.
(f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside.
(g) In addition to the requirements of section 429.41(1)(k), F.S., the use of physical by a facility on a resident must be reviewed by the resident's physician annually. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance, is not considered a physical .

429.28 Resident bill of rights.-
(1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to:
(a) Live in a safe and decent living environment, free from and neglect.
(b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy.
(c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of

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other residents.
(d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations.
(e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community.
(f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27.
(g) Share a room with his or her spouse if both are residents of the facility.
(h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather.
(i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident.
(j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making [illegible] for health care services, the provision of or arrangement of transportation to health care [illegible], and the performance of health

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A 030	Continued From page 15 care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without . . . , 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	A 030		

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prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder . . . . . Hotline operated by the Department of Children and Families, and, if applicable, ... , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder . . . . . Hotline operated by the Department of Children and Families, and , Rights Florida.

429.27 Property and personal affairs of residents.-
(1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated . . . , ... or . . . , ... under state law, managing his or her own affairs.
(b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall

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A 030	Continued From page 17 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 observations, record reviews and interviews, the facility failed to honor resident rights by physically restraining 1 of 12 sampled residents (#9). Findings: On at 10:02 a.m., resident #9 sat in a wheelchair at a table in the first-floor secured memory care dining room. The chair was locked, and she was alone and unengaged. A group of residents sat together in another common area. On at 10:56 a.m., the resident sat in a locked wheelchair at the same table in the dining room. She was alone and unengaged, and a group of residents sat together in the common area. On at 1:34 p.m., the resident sat in a locked wheelchair at the same table in the dining room. There were two other residents in the dining room, but they did not socialize with each other. When asked whether she could unlock the wheelchair, she made . , . contact then laughed. She then mumbled something that was incoherent. On . . . . . at 2:35 p.m., staff G said the resident was placed at the table with her wheelchair locked in order to prevent her from falling and said when the resident stood up her ⌣ became	A 030		

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A 030	Continued From page 18 wobbly. On . . . . . at 3:05 p.m., staff B said the resident was placed at the table with the wheelchair locked so she did not stand up and . . . . On . . . . . at 3:49 p.m., the memory care director said the resident did not do well around large groups of people, so she could not be placed in the common area around the other residents. She said when she was, she screamed and grabbed at the other residents. The director said the resident was placed at the table with the wheelchair locked for the resident's safety, and said the resident was able to release the brakes on her own but because her primary language was one other than English. She was unable to understand when instructed to release the brakes on command. When the memory care director was if there was a staff member who could translate, she said "No". Review of the resident's 1823s, dated . . . . . and . . . . , revealed she had a diagnosis of . . . . . , and restlessness and agitation with poor safety awareness. Class III	A 030		
A 055 SS=D	59A-36.008(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises.	A 055		

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A 055	Continued From page 19 Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents. (b) Both prescription and over-the-counter medications for residents must be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed; 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or 6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in rule 59A-36.006, F.A.C. (c) Centrally stored medications must be: 1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times; 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked;	A 055		

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A 055	Continued From page 20 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and, 4. Kept separately from the medications of other residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider. (e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to rule 64B16-28.870, F.A.C.	A 055		

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A 055	Continued From page 21 This Statute or Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to keep a centrally stored medication in a locked cabinet, locked cart, or other locked storage receptacle, room, or area at all times for 1 of 12 sampled residents (#8) and failed to return a medication to the resident's family when 1 of 12 resident's stay ended (#8). Findings: On at 11:05 a.m., the nursing supervisor's door near the second-floor dining room on the memory care unit was propped open with a chair. A small refrigerator in the room was unlocked and contained a box that held three , , ., none of which had been used. The label on the bag indicated the pens belonged to resident #8. Residents were seen walking by the room and had access to the unlocked refrigerator. On at 11:13 a.m., staff C confirmed the findings and said resident #8 was no longer a resident at the facility. She said the medication should have been securely stored. Review of resident #8's closed record revealed a facility admission date of and a discharge date of . The resident's record did not contain documentation to indicate the facility notified the resident's family to pick up the medication when the resident's stay ended. On at 4:40 p.m., the Regional Quality Aassurance Manager said the resident's family was not notified.	A 055		

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A 055	Continued From page 22 Class III	A 055		
A 152 SS=D	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable . to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, . . . or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who	A 152		

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A 152	Continued From page 23 require such services. Linens provided by a facility must be free of tears, stains and must not be [redacted]. This Statute or Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to maintain a safe and hazard free living environment. Findings: On at 10:19 a.m. during a tour of the secured memory care unit, a fire extinguisher was seen in a box mounted on the second floor near the elevator. The box did not have a cover which allowed unfettered access to the extinguisher. Staff C was present and said she did not know why a cover was not on the box. On at 10:22 a.m, staff F was seen passing the extinguisher twice without [redacted] the missing cover. When the surveyor asked her about it, she said she did not notice it was that way until it was brought to her attention. On at 10:24 a.m., the maintenance director responded to the unit and said most likely someone told him about the missing cover, but he could not fully recall. He removed the extinguisher from the box and left the unit. On at 10:31 a.m., both residents #3 and #4 were seen in the memory care common area. They shared a room, and their door was propped open. A small pair of scissors that had pointed tips was easily accessible on top of resident #4's dresser, which was located immediately to the left upon entering his room. Staff C was present and said if a resident's family signed a waiver, then the resident was able to keep those type of items	A 152		

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A 152	Continued From page 24 in their room, and said the room door was normally kept closed to prevent other residents from going into the room and harming themselves. Review of a fire drill revealed a drill was conducted in the 300 building, which was not memory care, on . On at 11:50 a.m., the maintenance director said the memory care extinguisher was not used during the fire drill on . On at 12:15 p.m., the maintenance director provided a small sticky note, dated , that indicated the fire extinguisher cover on the second floor of memory care needed to be replaced. He said he found it mixed in with papers on his desk. On at 12:40 p.m., the findings were discussed with both the administrator and the memory care director. The memory care director said that although there was a waiver form for items to be kept in a resident's room, it was allowed only when a resident did not have a roommate, which did not apply to residents #3 and #4. Review of resident #3's 1823, dated , revealed his diagnoses included and , . Review of resident #4's 1823, dated , revealed his diagnoses also included . Class III	A 152		

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CZ813	Continued From page 25	CZ813		
CZ813 SS=C	59A-35.090(3)(c), FAC Results of Screening & Notification In File 59A-35.090 Background Screening. (3) Results of Screening and Notification. (c) The eligibility results of employee screening and the signed Attestation referenced in subsection 59A-35.090(2), F.A.C., must be in the employee's personnel file, maintained by the provider. This Statute or Rule is not met as evidenced by: Based on personnel record review, Agency for Health Care Administration (AHCA) background screening website review and interview, the facility failed to ensure the current eligibility results of employee background screening were maintained in the personnel record for 2 of 7 sampled caregivers (F & G). Findings: 1. Caregiver F's personnel file revealed a hire date of , and a level 2 background screening with an eligibility date of , which expired as of . Review of AHCA's background screening website revealed an eligibility date of . 2. Caregiver G's personnel file revealed a hire date of , and a level 2 background screening with an eligibility date of , which expired as of . Review of AHCA's background screening website revealed an eligibility date of . On at 2:35PM, the administrator confirmed the current background screening results had not been printed and maintained in the personnel records.	CZ813		

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CZ813	Continued From page 26 Unclassified	CZ813		