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
	AL11969122	A. BUILDING: _____ B. WING _____	06/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RESIDENCE AT DANIA BEACH	150 STIRLING RD DANIA BEACH, FL 33004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced Relicensure with Limited Mental Health and Bed Capacity Increase, Complaints (#2020018765, #2020020375 and #2021004053), Focused Control and Generator Assessment surveys were conducted on through and at The Residence at Dania Beach. The facility had deficiencies identified related to the Relicensure and Complaint (#2020018765 and #2021004053) at the time of the survey.	A 000		
A 025	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident ' s representative or designee of the need for health care services and must assist in making for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident ' s representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 An assisted living facility must provide care and	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	A 025		

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.
(b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident.
(c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community.
(d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change.
(e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out.
(f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services.

This Statute or Rule is not met as evidenced by:
Based on record review and interview, the facility failed to reassess and provide appropriate supervision after a resident displayed signs of unsafe behaviors for 1 of 3 sampled residents reviewed for elopement (Resident #1) as evidenced by Resident #1 displaying increasing behaviors and subsequently eloping from the facility without facility staff being aware.

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A 025	Continued From page 2 The findings included: Review of the facility Elopement Policy and Procedure (Policy & Procedure / Process - Missing Person Elopement Response Team) 'Policy Statement: It is the policy of (The Facility)to provide a safe and secure environment for all residents. In the event of residents elopement, it is policy to implement it's policy/procedures immediately to locate the resident in a timely manner. All facility staff are a part of the facility Elopement Response Team. "Elopement" is referred to as an unauthorized absence of a resident from the facility. The risk of [redacted] and elopement increases when residents are mobile and [redacted] especially if they suffer from [redacted] or [redacted]' Review of the policy titled [redacted] Risk Scale Policy and Procedure documents, 'Residents will be assessed on Admission and reassessed whenever there is a change in Resident's clinical status. Residents who are identified at risk to [redacted] and high risk to [redacted] must have an individualized plan of care. Further review of the facility policy revealed a form titled Risk Assessment: Elopement- Answering "Yes " to any one question or a combination of the questions identify the resident at risk for [redacted] and potential elopement. An elopement can lead to possible danger and should be taken seriously. The facility documents resident elopement drills and ensure the drills are conducted consistent with the facility's resident elopement polices and procedures. The facility Administrator and all direct care staff are required to participate in drills.'	A 025		

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A 025	Continued From page 3 Review of the Incident account for Resident #1 revealed Resident #1 eloped from the facility on [redacted] around 2:00 AM using an emergency exit. The Director of Nursing (DON) notified the Administrator of the incident on [redacted] at 7:30 AM. The Administrator called the local hospital at 7:30 AM and found the resident there in the Emergency Room (ER) around 7:32 AM. The resident was doing just fine. According to the hospital, the resident was picked up by the police on a street close to the hospital and transferred to the hospital at 4:30 AM. The resident's psychiatrist was working at the hospital at the time and attended to the resident. The same day [redacted] around 11:00 AM, Resident #1 was discharged from the ER and transferred to another facility for a higher level of care. Family was notified. Analysis: Resident #1 was awake all night at the time of the incident walking up and down in the facility's hallways and at 2:00 AM opened the emergency exit door on the west side, went outside, got locked out, could not get [redacted] in and went towards the local area where she used to live. On her way there she was picked up by the police and dropped off at the hospital. Correction Action Summary (Corrective or Preventative Actions Taken): The administrative team had a meeting with all staff members and an employee training was conducted with the topics being, educational training and reinforcement of hourly rounds to be done for all the residents in the facility; Re-evaluation of all residents in the facility for their current mental status and possible mental status change. The facility developed a new method to identify residents who are at risk for elopement. The new risk assessment should be completed quarterly or more if residents condition changes.	A 025		

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A 025	Continued From page 4 On . . . . . at 9:30 AM, an interview was conducted with the Administrator who stated she received a phone call that morning around 7:30 AM, she was informed by the DON that Resident #1 was missing from the facility. She stated on her way to the facility she called the local hospital and found out the resident had been pick up by the police and brought to the ER. She spoke to the residents doctor who was working in the ER when the resident arrived, the doctor stated the resident was ok. She stated she returned to the facility and conducted an investigation which revealed Home Health Aide (HHA) Staff A heard the door alarm go off (unsure of time), and she looked down the hall and saw no one. HHA Staff A called Medication Technician (MT) Staff B and informed her the alarm went off. MT Staff B stated the last time she saw Resident #1 was around 2:00 AM. MT Staff B stated she was told by HHA Staff A that the exit door alarm sounded however, she did not do a . . . . count or check to make sure all of the residents were account for. The Administrator stated she reviewed the video cameras and determined the time stamp revealed Resident #1 went out of the southwest exit door of the facility at 12:24 AM. Once the door shut the resident could not get . . . . in. The cameras showed the resident walking north of the facility down the avenue to the rear parking lot of the facility; cameras showed the resident going through the facility . . . . parking lot and up another avenue to the front of the facility towards (major roadway) until she was out of view of the camera. She stated the Department of Children and Families and Law Enforcement came on and reviewed the cameras as well. The Administrator stated MT Staff B did not initiate a count or check to ensure all resident were accounted for, once she was informed the exit door alarm had gone off. She	A 025		

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A 025	Continued From page 5 also stated staff are supposed to check residents hourly and sign the Hourly Check Log however they were not doing it consistently. By the time she was notified, the morning shift staff had implemented the Elopement Policy and Procedure. At this time, the Administrator stated she submitted the Adverse Incident Report and she felt the facility did what they were supposed to do after the elopement. On . . . . . at 2:30 PM, an interview was conducted with MT Staff B, who stated she was assigned to Resident #1 at the time the elopement. MT Staff B stated the night of the incident there were three staff on duty and they received a new resident in the 500 unit, and he was acting a little strange so she was monitoring him. Resident #1 was sitting in a chair in the 200 Unit and she got up and left, stating she goes to the patio during the night or in the dining area patio. Resident #1 does not sleep well, and does not like to stay in her room, so she walks all night. She stated while she was in the 500 Unit monitoring the new resident, HHA Staff A called her a little before 2:00 AM, and asked if she heard the door alarm go off. She stated the alarm went off and she went to see if anyone was there and saw no one. She then went to the door and looked through the door and saw no one. She also asked the other two people on duty if they heard the alarm, they stated no. She made rounds but did not look for Resident#1 because she is usually outside on the patio or in the dining room patio. Resident#1 will not sleep in her room. It has been a good while that she refused to sleep in her room. It was reported to the DON and she stated they were considering moving her to a smaller facility. Resident #1 fights a lot with staff, and they could not get her to stay in her room. Resident #1 had a male friend who lived at	A 025		

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A 025	Continued From page 6 the facility and he, about 2 years ago, and she became more aggressive. Resident #1 walks all night, but there have been no signs or observations of her trying to leave the building prior to incident. Resident#1 had been moved to a new room with a roommate, and she did not get along with the roommate and she became more aggressive. Resident #1 became more and more and eventually they moved her to a private room. She did not conduct a count of residents as she did not know anyone was missing. The morning of the incident on, the DON held a meeting that notified us that Resident #1 had eloped, and we needed to be more attentive. An in-service by the Administrator, Elopement and Supervision was conducted. She stated she did receive a verbal warning and the DON said we have to be more alert. On at 4:45 PM a telephone interview was conducted with MT Staff G, who stated, she no longer works at the facility. On the day of the incident, MT Staff G stated during her morning rounds she discovered Resident #1 was missing. MT Staff G stated when she came in to work that morning, she went in to give Resident #1 her morning medications and the resident was not in her room, so she looked on the patio and around the facility. Once she could not find her, she asked other staff if they had seen her, and they said no. She reported to the DON and the staff started looking in all the rooms and around the outside of the facility. The Administrator was notified, and she called and found out the resident was in the hospital. A review of Resident #1's resident record revealed an admission date of . A review of the Agency for Health Care	A 025		

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A 025	Continued From page 7 Administration (AHCA Form 1823) dated revealed a diagnosis of Short Term Memory Loss and . Resident has a Slow Gait, is alert and oriented x 2, and at times. The AHCA Form 1823 documents Elopement Risk: No. Resident #1 is Independent with Ambulation, Eating, Toileting, Transferring, and Assistance is needed with Bathing, , and Self Care (1 person assist, due to refusal). Review of the facility Hourly Rounds Log dated , the night of the incident revealed, on the 11:00 PM-7:00 AM shift there were no signatures that the resident was observed from 12:00 AM-6:00 AM. Further review of the hourly checks log for the Month of leading up to the date of the incident, revealed there were no signatures for hourly supervision for 11:00 PM-7:00 AM for the following dates: through , , , , and on no signatures from 2:00 AM until 6:00 AM. During an interview with the Administrator on at approximately 2:00 PM, she stated the Hourly Rounds Logs have been a requirement since she has worked at the facility, however, staff are not always consistent with signing. Review of an Advanced Registered Nurse Practitioner note dated documented: Reason for Visit: Agitation, , , medication management, brief supporting , with focus on . Reported not easily redirected and resistant to care at times, looking for better outcomes. Judgement limited and Insight poor. Oriented to place, stable on current medications. Diagnosis: Unspecified with behavior disturbance- General	A 025		

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A 025	Continued From page 8 Review of Resident #1's Observation Notes revealed increasing behaviors being exhibited by Resident #1 to include: On [redacted] Resident #1 presented to nursing station agitated and complained of not getting along with roommate. On [redacted] resident refused showers and was verbally [redacted] to staff and her son had to be called to calm or coerce her into taking a shower. The DON followed up with doctor and the resident was prescribed ([redacted] medication) 5 milligrams (mg) daily. On [redacted] resident refused shower and was verbally [redacted] to staff. On [redacted] ([redacted] medication) increased from 5 mg to 15 mg twice daily. On [redacted] the 11:00 PM-7:00 AM shift staff reported episodes of Resident #1 refusing to go to her room and sleep, and refuse to shower and change clothes at times, referred to psych for medication management. On [redacted] resident refused shower. On [redacted] per night shift, resident refused to go to bed, stayed outside on the patio and slept in chair. Unable to assist with [redacted] care resident refused and fights staff. On [redacted] Resident #1 was seen by [redacted] doctor and ([redacted] medication 5 mg) at hour of sleep was ordered. On [redacted] several attempts were made to assist resident with shower and change of clothes. Resident's clothes are soiled and dirty. Resident is very combative and all attempts to shower and change clothes were refused. On [redacted] ([redacted]) 5 mg was ordered for 30 Days. On [redacted] a [redacted] was ordered and (additional [redacted]) increased to 50 mg every morning. On [redacted] ([redacted]) 5 mg was ordered. Per an interview conducted with the Administrator, the resident was not re-assessed for elopement risk after documented behavioral changes. On [redacted], Resident #1 was not	A 025		

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A 025	Continued From page 9 able to be found during morning rounds. During an interview with the Administrator on at approximately 2:00 PM, the supporting documentation of the corrective actions was requested. The Administrator provided an In-Service Sign-In sheet dated titled: Resident Supervision, Care and Medical Concerns, and Elopement Policy. Both direct care staff members involved attended the In-Service. The following people did not sign as participating in the In-Service: HHA Staff A, the person who initially heard the exit alarm; MT Staff G who discovered the resident missing, and the DON did not attend the In-Service. No Elopement Drills were conducted after Resident #1's elopement. Review of the Elopement Drill training revealed a drill on with the last Elopement Drill training on . For both drills there was no Elopement Drill form or sign-in sheet of signatures of who attended the training. Further review revealed no documentation of any re-evaluation of all residents in the facility for their current mental status and possible mental status changes. There was also no documentation provided of any resident risk assessment conducted after the elopement of Resident #1. The Administrator acknowledged the findings. Class III	A 025		
A 052	429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously	A 052		

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A 052	Continued From page 10 dispensed, properly labeled container, including an syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer, from where it is stored, and bringing it to the resident. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident ' s medications or dosages change. (c) Placing an oral dosage in the resident ' s or placing the dosage in another container and helping the resident by lifting the container to his or her . (d) Applying , medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the . (h) Using a to perform -level checks. (i) Assisting with putting on and taking off stockings. (j) Assisting with applying and removing an but not with titrating the	A 052		

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A 052	Continued From page 11 prescribed settings. (k) Assisting with the use of a continuous positive airway pressure device but not with titrating the prescribed setting of the device. (l) Assisting with measuring vital signs. (m) Assisting with bags. (4) Assistance with self-administration does not include: (a) Mixing, converting, or medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a of the body. (d) Administration of preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with , , or preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described	A 052		

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A 052	Continued From page 12 in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be , or older, trained to assist with self administered medication pursuant to the training requirements of rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in section 429.256, F.S. and this rule. (b) In addition to the specifications of section 429.256(3), F.S., assistance with self-administration of medication includes, in the presence of the resident, reading the medication label aloud and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a	A 052		

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	AL11969122	A. BUILDING: _____ B. WING _____	06/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RESIDENCE AT DANIA BEACH	150 STIRLING RD DANIA BEACH, FL 33004

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A 052	Continued From page 13 medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in section 429.256(4), F.S. 1. As used in section 429.256(4)(g), F.S., the term "competent resident" means that the resident is cognizant of when a medication is required and understands the purpose for taking the medication. 2. As used in section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (g) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure staff who assist with self-administration of medications took the medication in its prescribed container, and in the	A 052		

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A 052	Continued From page 14 presence of the resident, confirmed the medication was intended for the resident by stating the medication name and dosage for 2 of 13 sampled residents, Resident#25 and Resident #31 reviewed for medication pass observation. The findings included: 1) On . . . . . at 10:59 AM, a medication pass observation was conducted with Medication Technician (MT) Staff G. Upon the surveyor approaching the medication cart, it was observed Resident #25's medication were already prepared in the medication cup, prior to the resident coming to the medication cart. Resident #25 approached the medication cart and MT Staff G gave him his medications, he swallowed them and MT Staff G signed the electronic Medication Observation Record (MOR). Review of the signage on the electronic MOR and medication labels revealed MT Staff G prepoured 12 medications prior to Resident #25 being present to receive his medications at the medication cart. 2) On . . . . . at 11:10 AM, a medication pass observation was conducted with MT Staff G. This Surveyor observed Resident #31's medication sitting on top of the medication cart in a medication cup, prior to the resident coming to the medication cart. Resident #31 approached the medication cart and MT Staff G gave the resident her medications, she swallowed them and MT Staff G signed the electronic MOR. Review of signage on the electronic MOR and medication labels revealed MT Staff G prepoured 6 medications prior to Resident #31 being present to receive her medications at the medication cart. In an interview conducted with MT Staff G at this time, she stated she is new and has only been working on the medication cart by herself for one	A 052		

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A 052	Continued From page 15 week. Class III	A 052		
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	A 056		

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A 056	Continued From page 16 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 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,	A 056		

Agency for Health Care Administration

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A 056	Continued From page 17 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and, 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 record review and interview, it was determined the facility failed to follow a Physician's order by failing to administer medications for 1 of 10 sampled residents, Resident #4. The findings included: On at 9:13 AM, Resident #4 reported that all her medications were discontinued because she was having continuous . She said that this morning she did not receive any of her medications. She also reported that she was hospitalized and returned to the facility on . . . , . An interview conducted with Medication Technician (MT) Staff B at 9:21 AM, she confirmed Resident #4 did not receive any of her medications because the Pharmacy stopped all her medication the night before. MT Staff B stated the Medication Observation Record (MOR) is linked with the Pharmacy directly, and therefore they can remotely modify the record. The information provided by MT Staff B was verified on her computer screen revealing there were no active medications for Resident #4 the morning of	A 056		

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A 056	Continued From page 18 . . . . . Review of the . . . . . MOR revealed the medications Resident #4 was taking prior to the medications being discontinued in the pharmacy system included , , , , , , and . . . . . medications. Review of Resident #4's Health Assessment (AHCA form 1823) revealed diagnoses to include Ataxia, , , ... , and . . . . . The record indicated she required assistance with self-administration of medication. An interview was conducted with a MT Staff L on at 9:27 AM, who reported she told Resident #4 that there were no medications on the electronic MOR, that is why she could not give her any medications this morning. She also reported that the Nursing Director had called the Pharmacy yesterday regarding her orders, but she did not know what the outcome of that communication was. She was asked to provide the Pharmacy's name and the phone number. A telephone interview conducted with the Pharmacy Representative on . . . . . at 10:00 AM revealed that she had received the orders last night, on . . . . . . She said they faxed the orders twice to the facility this morning (. . . . .) and followed up with two phone calls to verify the accuracy of the orders before sending the new medications to the facility, but there no answer. The Pharmacy Representative said that their next scheduled delivery to the facility is this morning at 11:00 AM. She said that as soon as they confirm the medications to be delivered, they will send them. During an interview with the Nursing Director on	A 056		

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A 056	Continued From page 19 . . . . . at 10:08 AM, she confirmed that she did fax the new medication orders for Resident #4 to the Pharmacy on . . . . . , after 6:00 PM. The Nursing Director said that the Pharmacy did not immediately discontinue the medications as soon as they received the new orders on . . . . . , they discontinued everything the morning of . She stated that she faxed the discontinued orders to the Pharmacy first, then she called the Pharmacy to specifically inform them about the discontinued medications. She said that she spoke with a representative of the Pharmacy and informed her that only three medications were discontinued from the orders, and she told her that she was going to send the new orders approved by the Resident's Physician. Thereafter, she faxed the new orders. However, on , when she arrived at work, she saw the fax from the Pharmacy's Representative indicating for her to write a note to specify what medications should be sent to the facility which she did, yet every medication was already canceled in the system. The Nursing Director was asked if she could not use a paper MOR, to give the resident her medications in the morning, she said "Yes, that could have been done". Review of the . . . . . MOR revealed that the last date and time Resident #4 received her medications was on . . . . . at 5:00 PM. On . , for the 8:00 AM doses, Resident #4 did not receive any medications. Further, it was noted the . 8:00 PM doses were also not received. There was no indication that Resident #4 received her medications as the resident had expressed as the MORs were not signed. In a final interview with the Administrator on	A 056		

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A 056	Continued From page 20 . . . . . at 10:20 AM, she reported she had a meeting with the Pharmacy two weeks ago to discuss the problem of canceling all medications whenever they receive a new order. She said that she informed them to discontinue only the medications ordered to be discontinued, however, they still have not resolved the problem. Class III	A 056		
A 083	59A-36.011(5) FAC Training - First Aid and . (5) FIRST AID AND . . ( ). A staff member who has completed courses in First Aid and . and holds a currently valid card documenting completion of such courses must be in the facility at all times. (a) Documentation that the staff member possess current certification that requires the student to demonstrate, in person, that he or she is able to perform and which is issued by an instructor or training provider that is approved to provide training by the American Red Cross, the American . . Association, the National Safety Council, or an organization whose training is accredited by the Commission on Accreditation for Pre-Hospital Continuing Education satisfies this requirement. (b) A nurse shall be considered as having met the training requirement for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, Part III, F.S., shall be considered as having met the training requirements for both First Aid and C.P.R. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that at a minimum, one staff	A 083		

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A 083	Continued From page 21 person who holds a current and valid , , ( ) and First Aid certification is working on each shift. The findings included: An employee record review was conducted for Staff C who works as a Home Health Aide on the 11:00 PM - 7:00 AM shift. Staff C was noted to have a current certification on file, however there was no First Aid certification on file. Further review of the employee records for Staff M and Staff N, who are the additional staff that work the 11:00 PM - 7:00 AM shift, had current certification but no First Aid certification was in their files. At this time during an interview conducted with the Human Resources/Resident Service Director, she stated it was an oversight and they do not have a First Aid Certification for Staff C, Staff M, or Staff N, leaving the 11:00 PM - 7:00 AM shift without a certified First Aid staff member. Class III	A 083		
A 152	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	A 152		

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A 152	Continued From page 22 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 [illegible] to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, [illegible] or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be [illegible]. This Statute or Rule is not met as evidenced by: Based on observation and interview, it was determined there were environment concerns related to the lack of housekeeping and maintenance services in the facility. The findings included: On [illegible] at 10:05 AM, a tour was conducted in the one hundred section of the facility. The following was observed and noted: An open trash bin filled with trash observed in the	A 152		

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A 152	Continued From page 23 common area, in the activity area. The carpet at the entrance of was dirty. There was trash on the floor of and the trash bin in the room and in the bathroom were completely full. There was trash behind the door. Resident #3 said that "they do not clean". She said that she uses a sweeper to sweep the trash behind her door to keep the room clean. She added that she asked the Maintenance Director to have someone clean her windows, because she is , but they did not clean the windows. The windows were observed to be very dusty. By the nursing station, the carpet was observed to be very dirty. Also, it was noted that the double glass door on the East side in the hallway of the nursing station was filmed with spider webs. Outside, in the courtyard, it was observed that the air conditioner on the roof of the building was draining water down on the pavement creating a slippery algae area on the pathway. The conditions observed were brought to the attention of the Administrator and the Maintenance Director on at 11:05 AM, and they stated that they would immediately take care of them. On at 4:00 PM, it was noted that none of the identified issues were addressed. Further during tours of the facility on , the laminate wood floors were observed to be sticky, garbage was overflowing from trash cans throughout the facility, and a foul odor was noted in the bathroom in the main hallway. An interview was conducted with Resident #6 on at 10:00 AM who stated housekeeping has decreased to one day a week as opposed to daily. An interview was conducted with Resident #8 on at 11:20 AM who confirmed there is no housekeeping on a regular basis.	A 152		

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A 152	Continued From page 24 On . . . . . at 12:45 PM, an interview was conducted with the Director of Housekeeping/Maintenance and Laundry who confirmed for the past weeks they have been without housekeeping staff and he has been doing the cleaning as much as he can attempting to do a wing per day when he is not being called away. He confirmed resident rooms and bathrooms are not cleaned regularly and the focus is primarily on the common areas and also the kitchen if needed. On . . . . . during lunch time in the dining room, it was observed that the ceiling had multiple cracked/hairline openings as well as a plastered area with water marks. On the south corner of the dining room, there was a large powdered-like popcorn ceiling area that hung above where an unsampled resident sat for lunch. This powdery ceiling posed a health and safety hazard since the air could cause powdered particles to into the resident's meal, or over the resident's . . . . Also, the air conditioner vents, and its perimeter were dusty. After lunch on . . . . . at 1:46 PM, the Administrator and the Maintenance Director were informed. They said that they would address the concerns. On during lunch, it was observed and noted that not only the identified concerns were not addressed or rectified, but a resident was also allowed to sit under the powdered-like damaged popcorn ceiling. According to Bing.com :(The popcorn ceiling only becomes dangerous when it gets damaged, disturbed or begins to deteriorate. Damage allows dust that contains asbestos to float around in the air and possibly get inhaled by unsuspecting residents. Asbestos exposure has been linked to a rare form of called	A 152		

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A 152	Continued From page 25 mesothelioma in addition to . . . . breathing problems.) Before the exit meeting with the Administrator on . . . . . at 3:30 PM, only one of the identified issues was corrected. They picked up the trash in . . # . . . Class III	A 152		
AL243	429.075(1) FS; 59A-36.011(9) FAC LMH - Training 429.075 (1) To obtain a limited mental health license, a facility must hold a standard license as an assisted living facility, must not have any current uncorrected violations, and must ensure that, within 6 months after receiving a limited mental health license, the facility administrator and the staff of the facility who are in direct contact with mental health residents must complete training of no less than 6 hours related to their duties. This designation may be made at the time of initial licensure or relicensure or upon request in writing by a licensee under this part and part II of chapter 408. Notification of approval or denial of such request shall be made in accordance with this part, part II of chapter 408, and applicable rules. This training must be provided by or approved by the Department of Children and Families. 59A-36.011 (9) LIMITED MENTAL HEALTH TRAINING. (a) Pursuant to section 429.075, F.S., the administrator, managers and staff, who have direct contact with mental health residents in a licensed limited mental health facility, must receive the following training:	AL243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969122	A. BUILDING: _____ B. WING _____	06/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RESIDENCE AT DANIA BEACH	150 STIRLING RD DANIA BEACH, FL 33004

(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
AL243	Continued From page 26 1. A minimum of 6 hours of specialized training in working with individuals with mental health diagnoses. a. The training must be provided or approved by the Department of Children and Families and must be taken within 6 months of the facility's receiving a limited mental health license or within 6 months of employment in a limited mental health facility. b. Training received under this subparagraph may count once for 6 of the 12 hours of continuing education required for administrators and managers pursuant to section 429.52(5), F.S., and subsection (1) of this rule. 2. A minimum of 3 hours of continuing education, which may be provided by the ALF administrator, online, or through distance learning, biennially thereafter in subjects dealing with one or more of the following topics: a. Mental health diagnoses; and, b. Mental health treatment such as: (I) Mental health needs, services, behaviors and appropriate interventions; (II) Resident progress in achieving treatment goals; (III) How to recognize changes in the resident's status or condition that may affect other services received or may require intervention; and, ( ) Crisis services and the . . . . . procedures. 3. For administrators and managers, the continuing education requirement under this subsection will satisfy 3 of the 12 hours of continuing education required biennially pursuant to section 429.52(5), F.S., and subsection (1) of this rule. 4. Administrators, managers and direct contact staff affected by the continuing education requirement under this subsection shall have up	AL243		

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AL243	Continued From page 27	AL243		

to 6 months after the effective date of this rule to meet the training requirement.
(b) Administrators, managers and staff do not have to repeat the initial training should they change employers provided they present a copy of their training certificate to the current employer for retention in the facility's personnel files. They must also ensure that copies of the continuing education training certificates, pursuant to subparagraph (a)2. of this subsection, are retained in their personnel files.

This Statute or Rule is not met as evidenced by:
Based on record review and interview, the facility failed to ensure direct care staff completed 6 hours of Limited Mental Health (LMH) training within 6 months of receiving their LMH license. The facility also failed to ensure staff received 3 hours of continuing education credits related to LMH every two years for 4 of 4 sampled staff, the Administrator, Staff A, Staff B, and Staff C.

The findings included:

A review of the facility Standard License with Limited Mental Health was effective as of
.

An employee record review was conducted for the Administrator whose hire date was
, and the 6 hour LMH training would have been due by . Further review revealed no certificate of completion for 6 hours of initial LMH training. An interview was conducted with the Administrator who stated there was some discrepancy, and she sent a letter to the State licensing board asking that the LMH speciality be removed from their license. She was unable to provide any documentation to

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AL243	Continued From page 28 support the request for LMH to be removed from the license. Review of the facility's relicensure application to the State Health Care Licensing board dated , signed by the facility Financial Officer, documented the facility request for Standard relicensure with the Optional Specialty License of Limited Mental Health and not the removal of the Limited Mental Health specialty. A record review was conducted for Home Health Aide (HHA) Staff A whose hire date was . HHA Staff A completed the initial 8 hour LMH training on . There was no certificate of completion for 3 hours of continuing education related to LMH that was due by available for review in the employee record. A record review was conducted for Medication Technician (MT) Staff B whose hire date was . MT Staff B completed the initial 8 hour LMH training on . There was no certificate of completion for 3 hours of continuing education related to LMH that was due by available for review in the employee record. A record review was conducted for HHA Staff C whose hire date was . HHA Staff C completed the initial 8 hour LMH training on . There was no certificate of completion for 3 hours of continuing education related to LMH that was due by available for review in the employee record. During an interview with the Administrator and the Human Resources/Resident Service Director, they acknowledged the findings.	AL243		

Agency for Health Care Administration

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AL243	Continued From page 29 Class III	AL243		