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
	AL11968563	A. BUILDING: _____ B. WING _____	12/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING BREEZE ASSISTED LIVING FACILITY	5940 NW 19TH COURT LAUDERHILL, FL 33313

(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 (LMH) and Complaint Surveys (#2021015526, #2021015228 and #2021008866) was conducted on [redacted] through [redacted] at Morning Breeze Assisted Living Facility. The facility had deficiencies identified related to the Relicensure and Complaints (#2021015526 & #2021015228) 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 [redacted] 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 [redacted] or [redacted]. 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 [redacted] 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 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents	A 025		

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A 025	Continued From page 1 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 observation, interview and record review, the facility failed to ensure 10 of 10 residents residing in the facility requiring limited mental health specialty services, (Resident #1, Resident #2, Resident #3, Resident #4, Resident #5, Resident #6, Resident #7, Resident #8, Resident #9 and Resident #10), were provided with supervision levels to ensure their safety, due to the facility's practices this ultimately required	A 025		

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A 025	Continued From page 2 the removal and relocation of 10 of the 10 residents residing in the facility. The findings included: Review of an Emergency Medical Services ( ) Patient Care Record dated documented received a 911 call from the facility at 6:11 PM. The call was placed by Resident #2 of the facility in regards to the condition of Resident #3. arrived at the facility at 6:28 PM and had contact with Resident #3 at 6:30 PM. In an email correspondence dated from the to the Agency for Health Care Administration, upon arrival of to the facility at 6:28 PM, it was determined that 9 residents were present in the facility with no staff present. was informed by the residents the Assistant Administrator (AA) had left the facility and went to the store, however could not provide an actual time the AA had left. also observed the door to the facility office was open, and the medication cabinet was unlocked. It was determined by Resident #3 had consumed medication that did not belong to him. contacted the AA by phone, who arrived at the facility approximately 7 minutes after had responded. Upon arrival of the AA, he reported he had gone to the store. From the time the 911 call was placed by Resident #2 to the approximate time the AA returned to the facility was a minimum of 24 minutes the 9 residents were left unsupervised in the facility as it could not be determined what time the AA actually left the facility to go to the store. In that time Resident #3 had unsupervised access to the unlocked office and unlocked medication cabinet. Further review of the Patient Care Record documented departed the facility at 6:45 PM documenting their assessment and diagnosis for Resident #3 as an , reaction and emotional	A 025		

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A 025	Continued From page 3 upset. Upon arrival of the survey team on at 9:20 AM, observation was made of 2 residents sitting on the open patio area. The survey team was greeted by the AA approximately three minutes after entry through the facility gate. The AA was observed exiting the adjacent building A which houses the office. At this time, he greeted the surveyors and led the team into the dining and resident common area in building B where 6 additional residents were observed. An inquiry was made to the AA where the facility staff were at this time to which he stated he was the only employee present and was in charge of the facility. During the interview the AA confirmed he left the residents alone on (unknown time in the evening) but stated he only went to the store because he forgot something he needed to cook. The AA did not provide details of where the store was located or how long he was away from the facility. He further stated Resident #2 should not have called as the AA stated he did not think anything was wrong with running to the store with residents left unsupervised and with access to medications. During an interview with the AA on at 9:20 AM, he stated it was only he and one staff working at the facility, Staff A, a caregiver. However, Staff A was not currently present and was due to arrive later. The AA also stated the Administrator, also Owner #1, had about a month ago or so, and his brother, Owner #2 stated he did not want anything else to do with the business, so they were undergoing a change of ownership. However, he was unable to provide any proof or paperwork that a change of	A 025		

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A 025	Continued From page 4 ownership was taking place. On [redacted] at 9:38 AM, Staff A was observed arriving to the facility to begin her 8:00 AM - 8:00 PM shift. In an interview with Staff A at this time, she stated she just started working at the facility on Monday, [redacted] and is being trained by the AA. A request was made to review the required staffing hours and staffing schedule of the facility from the AA. The AA stated he did not have a current staffing schedule and was unable to produce prior schedules. Therefore, he was unable to provide evidence the facility maintained the required staffing hours of 212 for a census of 9 at the facility daily for a 24-hour period. At the time of this interview, there were only 2 employees working at the facility to provide supervision and assistance for 9 Limited Mental Health (LMH) residents. He stated that Owner #1 and Owner #2 were not involved in the staffing of the facility. According to the AA, Owner #1 [redacted] in [redacted] and the Owner #2 refuses to participate in anything regarding the facility. A review of the Tribute Archive website at http://www.tributearchive.com/obituaries revealed that Owner #1 of the facility actually [redacted] on [redacted]. In an interview with Owner #2, Owner #1's husband, on [redacted] at 11:42 AM, he stated he is 10% owner of the business, and his wife, Owner #1 was 90% owner and was also the prior Administrator. He stated he does not come inside the facility, does not oversee the facility and does not keep up with anything regarding the facility. He also stated he plans to give up everything and	A 025		

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A 025	Continued From page 5	A 025		

will not have any say in it. He further stated if his brother, the AA wants it, he will give it up, or sell it, according to what the AA wants to do, and that he does not want to do anything. He also stated it has been about 9 months since he has been present at the facility.

Owner #2 further stated in the interview on [redacted] at 11:42 AM, he has not submitted anything to the state regarding transferring ownership. He stated he has not submitted a license renewal request, and he does not keep in touch with anything and just wants out of the business.

A review of documents and interviews with the AA revealed residents of the facility are not supervised or required to sign in or out as a means of knowing their whereabouts. On [redacted] at 12:17 PM this surveyor observed the AA [redacted] medications to Resident #3 to take as he was going to visit his family for a few days. However, Resident #3 did not sign out of the facility prior to leaving. A request was made to the AA for the facility's Sign-In/Sign-Out log and stated he does not have one, nor does he provide supervision and monitoring of residents, and that they are free to come and go.

In an interview with Resident #4 on [redacted] at 12:58 PM, he stated he has been at the facility for about a year and has been left alone along with the other residents. He was not able to provide dates and times in which the facility had no staff present.

In an interview with the AA on [redacted] at 2:44 PM, he stated he has been the only employee at the facility since [redacted]. He stated he recently hired another employee Staff A on

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A 025	Continued From page 6 , who began working on to work the 8:00 AM to 8:00 PM shift. He further stated he is currently residing at the facility and has since , due to the absence of additional staff needed in which he was unable to hire due to financial issues. Upon arriving at the facility on at 9:03 AM, the surveyors observed the AA was not on site, only Staff A was present. In an interview with Staff A at this time, she stated "he had to go to the store for more bread." Staff A confirmed she was designated as the person in charge in the absence of the Manager. She was asked if there was documentation indicating this designation and she stated "No". Further observations of the facility confirmed the AA was not present in the facility and Staff A was the sole person in charge. The AA returned to the facility at 9:17 AM. On at 9:16 AM, observation was made of the Case Manager for Resident #4 and Resident #6, enter the facility. When asked of the nature of the visit, the Case Manager replied, I am here to pick up Resident #4 and Resident #6 to take them to a picnic. However, Resident #4 was not able to be located within the facility. The Case Manager asked Staff A where the resident was, and she stated she did not know where the resident was. The Case Manager responded, "I think he went to the store, I'll pick him up there." Further interview with Staff A, revealed she was not aware that any residents had left the facility. She confirmed she started her shift at 8:00 AM. She was asked if upon arrival to start her shift, if she had observed or conducted a physical check on the residents to confirm who was present, to which she stated "No". On at 11:38 AM, observation was	A 025		

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A 025	Continued From page 7 made of Resident #6 drive off in the AA's car, and the AA was observed in the office area during the time of Resident #6's departure and absence from the facility. A review of Resident #6's Resident Health Assessment (AHCA 1823 form) dated documented his diagnoses which included , and , . Resident #6 returned to the facility approximately 30 minutes later. Resident #6 with bags in his proceeded to go into the kitchen to prepare the lunch meal. The AA was questioned regarding this incident, to which he stated Resident #6 helps him in the kitchen because of his injury. The AA further stated he is as a result of his injury. In an interview with the AA on at 2:39 PM, he stated the newly appointed Administrator of record would come to the facility once or twice a month, and he would only call her if needed as she had her own way of doing things. He also stated after his sister-in-law, the 90% Owner #1 , , his brother Owner #2 wanted to sell the facility, but he did not want to do that right away. The AA also stated he did not know that the ownership and license with Owner #1. The AA was requested to contact the Administrator of record for further discussion regarding the circumstances at the facility, including the supervision issues and to come to the facility to meet with the surveyors. The AA was observed calling the Administrator, however per the AA, she refused to come to the facility and refused to communicate with the surveyors. During a further interview conducted with the AA on at 2:58 PM, he stated his brother, Owner #2 owns the facility and the property, however he does not oversee the facility or provide any financial support to the daily	A 025		

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A 025	Continued From page 8 operation of the facility. He further restated at this time, he has only 1 employee, Staff A who started working on [redacted] and himself working at the facility. He stated it is difficult to manage the facility, supervise the residents and hire staff. He also stated he does not watch the residents as they are responsible, so he gives them freedom. He was informed of the supervision responsibility in an Assisted Living Facility, which his facility is. He acknowledged and responded that his brother, Owner #2 does not provide him any help, so it is him alone. He further stated the residents are responsible and would not go anywhere, and he does not watch over them like that. On at 10:10 AM, the AA was observed asking Resident #2 if he knew the whereabouts of Resident #9. Resident #2 advised him that Resident #9 had gone to his Day Program. In an interview with the AA on [redacted] at 10:21 AM, he stated he does not have a sign-in or sign-out log for residents or visitors. As such he is not aware of the goings and comings of the residents of the facility. On a request was made to the AA for the facility's Policy & Procedures regarding supervision, care and services for the residents. He provided a blue binder containing the facility's policies. A review of the facility's "Policy and Procedures" manual did not reveal a policy on Supervision. In an interview conducted with the AA on [redacted] at 11:48 AM, the AA was informed the the facility Policy and Procedure binder did not contain a policy on supervision. The AA stated, "That is all I have in the book. I may have some other papers around, but I do not know where they might be, everything is scattered all about." No additional documents were provided during the survey.	A 025		

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A 025	Continued From page 9 Review of Resident #1 through Resident #9's records revealed they all suffer from limited mental health (LMH) diagnoses and require supervision to ensure their safety. All 9 residents require assistance with activities of daily living (ADLs), medication assistance and are under Case Management services for their LMH diagnoses. Observations of the residents in the facility on through revealed a lack of supervision by the AA and Staff A. Neither were observed checking the whereabouts or safety of the residents. Further observations revealed Staff A worked on and . However, she did not return to work, therefore leaving AA as the sole employee to oversee the 9 residents. On at 3:38 PM, Resident #6 was observed driving away again in the AA's car. He returned approximately 15 to 20 minutes later. In an interview with the AA at 4:11 PM on , he stated Resident #6 washes his car and runs errands for him and the facility because of his . An inquiry was made to the AA how he is ensuring the safety and supervision of Resident #6 driving his car to which the AA responded he needs the help. During an interview conducted with the AA on , it was revealed the facility had a 10th resident that was not counted originally in the census provided by the AA at the initiation of the survey due to the resident being hospitalized. The AA was asked to provide information regarding the incident and/or circumstances surrounding the hospitalization of Resident #10 and the AHCA 1823 form. The AA stated he did not have a file and was unable to provide the requested information verbally or written.	A 025		

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A 025	Continued From page 10 Additionally, the AA was observed to be in his office/sleeping quarters in the separate building A with the exception of intermittently coming out to prepare breakfast, lunch, or giving medications and residents were observed freely moving about unsupervised in building B where their rooms, kitchen and medications are located. As a result, the AA is unaware of resident whereabouts and provides little to no supervision of residents as observed throughout the onsite survey conducted on through . Class I	A 025		
A 077	429.176 FS; 429.52( ),59A-36.01(1) FAC Staffing Standards - Administrators 429.176 Notice of change of administrator.-If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator meets educational requirements and has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who has completed the core educational requirements. 429.52 (4) A facility administrator must complete the required core training, including the competency test, within 90 days after the date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19. Administrators licensed in accordance with part II	A 077		

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A 077	Continued From page 11 of chapter 468 are exempt from this requirement. Other licensed professionals may be exempted, as determined by the agency by rule. (5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years. 59A-36.010 (1) ADMINISTRATORS. Every facility must be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents as required by chapters 408, part II, 429, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter. (a) An administrator must: 1. Be at least [illegible]; 2. If employed on or after [illegible], have, at a minimum, a high school diploma or G.E.D.; 3. Be in compliance with Level 2 background screening requirements pursuant to sections 408.809 and 429.174, F.S.; 4. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C., no later than 90 days after becoming employed as a facility administrator. Administrators who attended core training prior to [illegible], are not required to take the competency test unless specified elsewhere in this rule; and, 5. Satisfy the continuing education requirements pursuant to rule 59A-36.011, F.A.C. Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect on the date the non-compliance is discovered by the agency or the department.	A 077		

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A 077	Continued From page 12 (b) In the event of extenuating circumstances, such as the of a facility administrator, the agency may permit an individual who otherwise has not satisfied the training requirements of subparagraph (1)(a)4. of this rule, to temporarily serve as the facility administrator for a period not to exceed 90 days. During the 90 day period, the individual temporarily serving as facility administrator must: 1. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C.; and, 2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility. (c) Administrators may supervise a maximum of either three assisted living facilities or a group of facilities on a single campus providing housing and health care Administrators who supervise more than one facility must appoint in writing a separate manager for each facility. However, an administrator supervising a maximum of three assisted living facilities, each licensed for 16 or fewer beds and all within a 15 mile of each other, is only required to appoint two managers to assist in the operation and maintenance of those facilities. (d) An individual serving as a manager must satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements as an administrator pursuant to paragraph (1)(a) of this rule. Managers who attended the core training program prior to , , , , are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as a manager of more than a single facility, except as provided in paragraph (1)(c) of this rule, and	A 077		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING BREEZE ASSISTED LIVING FACILITY	5940 NW 19TH COURT LAUDERHILL, FL 33313

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A 077	Continued From page 13 may not , serve as an administrator of any other facility. (e) Pursuant to section 429.176, F.S., facility owners must notify the Agency Central Office within 10 days of a change in facility administrator on the Notification of Change of Administrator form, AHCA Form 3180-1006, , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-09393. This Statute or Rule is not met as evidenced by: Based on interview and record review the facility failed to notify the Agency for Health Care Administration of a change in Administrator within ten 10 days of the change. The facility was also operated by unqualified personnel beyond the 90 day requirement. The findings included: During an interview conducted with the Assistant Administrator (AA) on at 9:28 AM, it was revealed the Owner/Administrator of the facility , , earlier in the year. A review of the Tribute Archive website at http://www.tributearchive.com/obituaries revealed that the owner, Owner #1 of the facility , , on , . The AA further stated in the interview on at 9:28 AM, that he is the Assistant Administrator (AA) and has been running the facility since , . As such, the AA has been acting as Administrator for more than 90 days. In addition, the AA has operated the facility	A 077		

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A 077	Continued From page 14 for more than 120 consecutive days during which there was no Administrator present who met the mandatory CORE training requirements. In an interview conducted with the AA on [redacted] at 2:39 PM, he stated the newly appointed Administrator of record would come to the facility once or twice a month, and he would only call her if needed as she had her own way of doing things. The AA confirmed the Administrator of record had very little to do with the facility. A review of the AAs personnel file on [redacted] revealed the AA received his CORE certification on [redacted] as documented on the certificate in the file. Review also revealed the only documentation of the required 12 hours of mandatory continuing education required every two years was dated [redacted] as documented on the certificate in the file. No other continuing education documentation was observed in the file. As the AA failed to meet the requirements of obtaining the mandatory 12 hours of continuing education every two years, the AA is required to retake the CORE training and CORE competency test requirements in effect on the date the non-compliance was discovered on [redacted]. In an interview conducted with the AA on [redacted] at 2:57 PM, he stated he was aware the training was not current. In addition, review of the AA's personnel file revealed the AA completed the initial 8 hours of limited mental health (LMH) training on [redacted], as documented on the certificate in his personnel file. Review also revealed a 3 hour LMH training on [redacted] as documented on the certificate in his personnel file. However, the AA did not have the additional 3 hours of continuing education required every 2 years. The	A 077		

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A 077	Continued From page 15 facility has a specialty license as a Limited Mental Health facility. Review of Resident #1 through Resident #9's records, revealed they all suffer from LMH diagnoses and require supervision to ensure their safety. All 9 residents require assistance with activities of daily living, medication assistance and are under Case Management services for their LMH diagnoses. As Owner #1 who was also the Administrator, , on , the current Administrator of record was not involved in the day-to-day operations of the facility. Further the AA, did not meet the continuing education requirements, the facility has been operating without qualified personnel onsite to provide the appropriate care and supervision of the 9 LMH residents currently residing in the facility. Class II	A 077		
A 120	429.17(3) .275(1); 59A-36.013(1) FAC Fiscal - Financial Stability 429.17 (3) In addition to the requirements of part II of chapter 408, each facility must report to the agency any adverse court action concerning the facility's financial viability, within 7 days after its occurrence. The agency shall have access to books, records, and any other financial documents maintained by the facility to the extent necessary to determine the facility's financial stability. 429.275 (1) The administrator or owner of a facility shall maintain accurate business records that identify, summarize, and classify funds received and	A 120		

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A 120	Continued From page 16 expenses disbursed and shall use written accounting procedures and a recognized accounting system. 59A-36.013 Fiscal Standards. (1) FINANCIAL STABILITY. The facility must be administered on a sound financial basis in order to ensure adequate resources to meet resident needs pursuant to the requirements of chapter 408, part II, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain financial stability to ensure the care, services, safety and supervision was provided for 10 of the 10 residents residing in the facility. The findings included: In an interview conducted with the Assistant Administrator (AA) on at 9:28 AM, he stated Owner #1 who was also the Administrator of the facility, , earlier in the year. A review of the Tribute Archive website at http://www.tributearchive.com/obituaries revealed that Owner #1 of the facility , , on . The AA further stated in the interview conducted on at 9:28 AM, Owner #1 owned 90% of the business, and his brother, Owner #2 and husband to Owner #1 owns 10% of the business. A review of Sunbiz.org Division of Corporations website at: Division of Corporations - Florida Department of State (myflorida.com) revealed Owner #1 ( ) as Primary Officer/Director and Owner #2 as Secondary Officer/Director.	A 120		

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A 120	Continued From page 17 In an interview conducted with Owner #2 on , he stated he owns 10% of the business and Owner #1 owned 90% of the business. He further stated he wants nothing to do with the business and will not be renewing his license. He stated he is not operating the facility or providing any oversight for the residents or the maintenance of the facility and that all matters related to the facility is being handled by his brother, the AA. In an interview with the AA on at 2:39 PM, he stated he works at the facility as a volunteer and does not get any money. He stated it is a family business, and his brother, Owner #2 would save up the money. He further stated Owner #2 wanted to sell the facility and asked him, AA why he does not just rent the facility from him. He stated Owner #2 realized the facility has no money to pay him, and that Owner #2 had taken out all the money before his wife, Owner #1 The AA further stated in the interview conducted on at 2:39 PM, the facility is running on minimal income from Social Security and Medicaid, and that he increased the price and started taking higher residents in order to pay the bills. He stated the money goes into the account that Owner #1 and Owner #2 set up, and that he is a signatory of the account as well. As such, he puts money into the account and takes money out of the account to pay the bills. He stated he is not receiving any Medicaid funds at this time, and there are no funds coming from the Medicaid Long Term Care Plan he is enrolled with. The AA stated in the interview that the water bill is past due, and that he just pays the minimum due on the other facility bills for example the electricity and cable. He further stated he has used some of	A 120		

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A 120	Continued From page 18 his personal funds he receives from . . . . . , to deposit into the account to assist with the business expenses. The AA further stated Owner #2 does not provide any funding currently for the facility and is not overseeing its finances. A request was made for documentation of the utility bills reflecting the current status of each. On . . . . . at 2:24 PM during an interview conducted with the AA he confessed he has not paid the water company for a couple of months now. A request was made for the financial documents related to the operations of the facility. In an interview conducted with the AA on at 2:47 PM, the AA provided the Florida Power and Light (FPL) bill for building A, where the AA resides, with a statement date of . . . . . , with a balance of $294.58 due by , and an FPL bill with a statement date of . . . . . , with a balance of $424.24 due by for building B where the residents reside. The AA could not produce the statements for any other facility related expenses such as water and cable. A review of the facility's Business Account at (name of bank) on at 2:53 PM, revealed a current balance of $4,019.06. The AA stated the amount reflected the current finances available for the facility operations. The AA was not able to provide an accounting of the monthly cost of operating the facility. He restated that Owner #2 does not provide any financial support for the facility, so he has to pay the minimum of each bill every month, and that he shops for groceries as needed to ensure there is enough funds for the month. On at 12:15 PM, the AA was	A 120		

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A 120	Continued From page 19 observed in the dining room asking 3 residents what they wanted to eat for lunch. Resident #6 was observed assisting in the kitchen. At 12:59 PM, observation was conducted of 5 residents seated in the dining room passing a bag of popcorn amongst them that Resident #6 gave to them from the kitchen. 3 residents were observed pouring the popcorn onto their plate. Resident #9 was observed reaching into the bag and putting a handful of popcorn on his plate then passed the bag along to Resident #1. Observation of the breakfast, lunch and dinner meals by this Surveyor on through revealed the facility does not follow the dietitian approved menu, resulting in residents getting "at will" meals with no guarantee of nutritional value. During a follow up tour of the facility on commencing at 9:04 AM, the following concerns were noted: In # , there was a plate of food, consisting of crackers and cheese, was observed on top of two night stands that were stacked on top of each other. There was also a plate of food left on top of a dresser that consisted of what appeared to be cinnamon and raisin bread. When Resident #2 was asked about the food the resident replied, "that has been there since last night." It was noted that the makeshift dresser had some damage to the surfaces and that the room smelled of dirty laundry. In # , the furniture showed signs of wear and the room had an odor of dirty laundry. In # , there was an electric coffee maker on a dresser that was damaged and the dressers in the room showed signs of wear. At the entrance to the room, the floor was heavily soiled and the walls had some small holes in them. The furniture in the room showed wear and	A 120		

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A 120	Continued From page 20	A 120		

the room had an odor. In the dining area, there were multiple areas on the walls that were unfinished and some areas that were damaged and the baseboards were heavily soiled. The chair rail that had been installed around the perimeter of the dining area was made of unfinished and raw wood that is porous and uncleanable and the chair rail was not sealed to the wall, creating a gap at the top of the uncleanable chair rail. The ceiling over a refrigerator located at the entrance to the kitchen was damaged and the ceiling mounted fan was missing a blade. In . . . # , there was a laundry hamper that was overflowing, the furniture showed signs of wear, the floor and base boards were soiled and stained, and the room had an odor. In . . . # , there was a portion of the wall, to the right side of the window that had been repaired but not finished (painted), and the curtain rod was bent in a manner that the curtain could not be closed all the way for privacy and the room floors and baseboards were stained and soiled. In the common area/living room, the vent cover over the air intake was damaged and there was an accumulation of dust on the vent and a ceiling mounted fan was missing a blade. The floors throughout the facility were observed to be extremely dirty and never cleaned during the observations conducted from . . . . . through . (Photographic evidence obtained.)

On . . . . . , during an interview conducted with the AA at 3:00 PM, he stated some residents are currently out at the local laundromat as the facility's washing machine is broken. Additionally, resident items needed included, for example new bedding and broken furniture were not being repaired or provided. As a result, residents are not receiving the care and services required due to the financial instability of the facility.

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A 120	Continued From page 21 Class II	A 120		