

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969042	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 02/16/2022
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BETHESDA ASSISTED LIVING, LLC

**624 BARBER AVE
LAKE WORTH, FL 33461**

(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 revisit to complaint survey (#2020016979) was conducted on 02/16/2022 at Bethesda Assisted Living, LLC. The previously cited deficiency was found uncorrected at the time of this survey.	{A 000}		
{CZ28}	408.813(3) FS Administrative Fines; Violations 408.813 Administrative fines; violations -As a penalty for any violation of this part, authorizing statutes, or applicable rules, the agency may impose an administrative fine. (3) The agency may impose an administrative fine for a violation that is not designated as a class I, class II, class III, or class IV violation. Unless otherwise specified by law, the amount of the fine may not exceed \$500 for each violation. Unclassified violations include: (a) Violating any term or condition of a license. (b) Violating any provision of this part, authorizing statutes, or applicable rules. (c) Exceeding licensed capacity. (d) Providing services beyond the scope of the license. (e) Violating a moratorium imposed pursuant to s. 408.814. (f) Violating the parental consent requirements of s. 1014.06 This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that it did not exceed its licensed capacity for occupancy limit of 5 residents by having 1 additional resident (resident #1) who lived in the facility. The findings included:	{CZ28}		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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{CZ828}	Continued From page 1 In an interview with Resident #1 on _____ at 9:00am, he stated that he lived there and that there were a total of 6 residents (Resident #1-#6) who lived in the facility. He stated that since the Administrator was not onsite and the Caregiver didn't understand English language too well, he may contact the Administrator by telephone so she may be present during this inspection. In an observation on _____ at 9:15am, there were a total of 6 residents in the facility. Residents #1 and 4 were sitting in the dining room table, Resident #7 was sleeping in the living room, Resident #3 was in his bedroom watching television, Resident #2 was smoking a cigarette in the patio and Resident #6 was sleeping in the patio. Further observation of the physical environment of the facility revealed that there were a total of 3 bedrooms with one bedroom having 3 beds and the 2 remaining bedrooms having 2 beds each, which totaled 7 beds inside the facility. In an observation at this time, there was an additional fold-up bed located in the patio. (Photographic evidence was obtained). In an observation on _____ at 9:25am in the filing cabinet next to the laundry room, there were numerous resident medications being stored inside the third cabinet drawer. In an observation at this time, the medications for Residents #1, 2, 3, 4, 6 and 7 were being stored there, including medications for resident #1 which were prescribed to be taken at bedtime. In an observation of Resident #1's bedtime medications at this time, there were 10 medication containers with 4 different medications that included Mirtazipine 15mg tablets, Prazosin 2mg capsules, _____ 1mg tablets and _____ 500mg tablets. (Photographic evidence was obtained).	{CZ828}			

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{CZ828}	Continued From page 2 In an interview with the Administrator on at 9:40am, she stated that Resident #1 was a day care client and that he was dropped off and picked up from the facility every day by the resident's son. She stated that the facility had a contract to represent that he resident was a day care client. She stated that she personally assisted resident #1 with his medications every day and that she gave the resident his bedtime medications at 6pm while he was in the facility and before he got picked up by his son. Review of Resident #1's contract provided by the administrator, which was titled "Bethesda ALF Agreement" revealed that it was not dated and it did not contain any resident signature or initials. Further review of this document revealed that the billing rate was \$1,738.00 per month for a semi-private room and page 1 had a handwritten statement "day care patient family pick up in the evening". In an interview with the Administrator on at 9:45am, she stated that she could not provide proof of payment or deposit for the \$1,738.00 amount represented in Resident #1's contract. She stated that it would take a day or so for her to produce proof of payments from the bank for this monthly amount. She stated that although Resident #1 was previously a resident in the facility, she did not keep any of this resident's records for review in the facility, including any discharge records. In an interview with Resident #1 on at 9:50am, he recanted his previous statement and stated that he was a day care client and he got dropped off and picked up by his son every day from 6am to 7pm. He stated to not attempt to reach his son by telephone before his son	{CZ828}		

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{CZ828}	Continued From page 3 finished his work day, usually at around 5 or 6pm. In an interview with the Administrator on at 10:40am, she stated that she was aware that the facility was licensed with an occupancy capacity of 5 resident beds and that there were presently a total of 7 physical beds inside the 3 bedrooms of the facility. She stated that the facility did not seek any permission from the local municipality to ensure that the facility met local zoning and building code requirements by operating an adult day care within the facility. In the first attempt to reach Resident #1's by telephone on at 10:10am, a voicemail message was left and on the second attempt on at 9:45am, there was no answer. Unclassified	{CZ828}		