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
	AL11969358	A. BUILDING: _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BANYAN PLACE-LANTANA	1021 RIDGE RD LANTANA, FL 33462

(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 Change of Ownership (CHOW), Complaints (#2022007112 & #2022007236) and Generator Monitoring survey was conducted from [redacted] to [redacted] at Banyan Place Lantana. The facility had deficiencies related to the Change of Ownership and Complaint (#2022007112 & #2022007236) 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 has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [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		

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 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 provide appropriate personal supervision of care and daily observations to ensure the general health, safety and well-being for 3 out of 12 residents (residents #2, Resident #3 and Resident #4) who were assessed to be at-risk for . The findings included:	A 025		

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A 025	Continued From page 2 Review of the facility's undated " " policies and procedures revealed the following: "Should a resident experience a , staff will provide or arrange for necessary emergency care, and will follow up with necessary service plan updates. Procedure: Should the resident have . . . . resulting in deformity, exhibit any change in level of . . . . . , received obvious . . . or significant the Administrator or caregivers summon emergency medical services (call 911). When a resident care givers are instructed to summon immediate assistance from the Administrator or another caregiver. Caregivers do not move the resident, except to protect against further injury, as in the case of a dangerous environment. The physician is contacted for further instructions if the . . . was not involved in the and the resident is able to move all extremities. The Administrator instructs caregivers to provide appropriate care and frequent resident checks. Any change in status is reported to the Administrator. An incident report is completed. The Administrator informs the physician of subsequent . . and instability. Medical intervention, , , , , , and/or gait analysis is arranged when residents remain a significant risk for . Ongoing . . may require relocation from the community." Review of the facility's undated "Ongoing Resident Appraisals" policies and procedures included the following: Residents are assessed/evaluated on an ongoing basis. Procedure:	A 025		

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A 025	Continued From page 3 Daily Evaluations. One-Month Resident Appraisal. Quarterly Resident Appraisal. Residents are formally assessed on a quarterly basis." 1) In an observation conducted on at 10:15 AM, Resident #2 was aimlessly walking about the facility without staff supervision or assistance. The resident attempted to open the door to resident # , and this door presented to be locked because he was unable to open it. The resident also presented to be at this time and he had a visible, discolored to his left forehead and , , and scrapes on his left . In an interview conducted with Caregiver Staff C on at 10:20 AM, she stated that Resident #2 suffered a on or about and went to the hospital, but she didn't know when the resident returned to the facility. She stated that she was used to seeing him walk about the facility independently and she did not know the resident's current functional activities of daily living status. Review of Resident #2's record documented that he was admitted to the facility on and his most recent health assessment dated revealed that he was diagnosed with , , , loss of memory, , and , . Review of this Heath Assessment documented the resident had poor sensory and abnormal gait, and was at risk for . Further review of this Health Assessment documented the resident needed assistance with bathing and grooming, supervision with , and assistance with self-administration of medications.	A 025		

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A 025	Continued From page 4 Review of Resident #2's Discharge Evaluation dated documented the resident was diagnosed with gait abnormality, lack of coordination and , and needed assistance with all activities including transfers and toileting. Further review of this resident's record documented that there were no other recent evaluations, ongoing monthly/quarterly assessments or facility interventions documented to prevent further injuries from accidents/. Review of the facility's Reports, it revealed that Resident #2 most recently on and sustained injuries. Previous at the facility were recorded on and . Further review of this record documented the resident was hospitalized on at 10:00 AM due to an unwitnessed/unsupervised and he suffered extensive (hematoma) to his and scrapes to left arm, the resident was found on the floor in the hallway outside a resident's room and resident returned to the facility on . In an interview conducted with Nurse Staff A on at 10:35 AM, she stated Resident #2 in the facility on while ambulating in the hallway outside a resident's room. She stated that the resident suffered injuries to his and left arm, and was hospitalized for treatment. She stated the resident returned to the facility the same day and was receiving home health/ services before and after his on . She stated that she was not aware of the resident's specific functional activities of daily living status as established by the Home Health Skilled Nursing and services the resident presently received.	A 025		

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A 025	Continued From page 5 She stated that the Home Health documentation was not in the resident's record so the facility may determine the resident's most recent health status to provide adequate personal care services. In an interview conducted with Nurse Staff A on at 1:15 PM, she stated the facility had very limited documentation from the Home Health rehabilitation services the residents received at the facility. She stated she spoke with the Physical , earlier on , but she did not inquire about Residents #2 or Resident #4's level of care required to prevent future injuries from /accidents. She stated Resident #4 also in the facility sometime in due to his and she didn't know if the resident sustained an injury. She stated the resident received continuous services and she believed that the resident needed supervision with ambulation and used a wheelchair. 2) Review of the facility's Report, it revealed that Resident #4 most recently on and this event was not witnessed. Previous at the facility were recorded on , and . Review of Resident #4's record documented he was admitted to the facility on and his Health Assessment dated revealed that he was diagnosed with , , and . Review of this Health Assessment documented the resident was forgetful and was at risk for . Further review of this Health Assessment documented the resident needed supervision with ambulation, bathing, toileting, , grooming and transfers, and assistance with	A 025		

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A 025	Continued From page 6 self-administration of medications. Further review of this resident's record documented there were no ongoing monthly/quarterly assessments or facility interventions documented to prevent further injuries from accidents/ . . Review of Resident #4's , ... , , Re-evaluation dated documented the resident was diagnosed with gait abnormality, lack of coordination and , and needed . precautions and supervision with activities including ambulation and transfers, using a wheeled walker. Review of this resident's , , Notes dated documented the resident needed . precautions and supervision with activities including ambulation and transfers. Further review of this resident's record documented there were no other ongoing monthly/quarterly assessments or facility interventions documented to prevent further injuries from accidents/ . . 3) Review of the facility's Report, it revealed that Resident #3 most recently on at 1:39 PM and on the same day at 6:45 PM. The resident had 2 scratches on her from an unknown source. Previous . . at the facility were recorded on . and . In an interview conducted with Nurse Staff A on . . . . . at 1:45 PM, she stated Resident #3 was previous prescribed Physical and , . . , , services, but the resident has not received any of these rehabilitation services due to issues with insurance not being able to pay for the services. She stated she was not aware of the resident's specific functional activities of daily living status. Review of Resident #3's record documented she	A 025		

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A 025	Continued From page 7 was admitted to the facility on and her Health Assessment dated revealed she was diagnosed with and . Review of this Heath Assessment documented the resident had poor vision and moderate with paranoia, and was at risk for and elopement. Further review of this Health Assessment documented the resident needed assistance with bathing, toileting, and grooming, supervision with ambulation and transfers, and assistance with self-administration of medications. Review of this resident's record revealed there were Physician Orders to receive Physical and on and and there were no Physical or Evaluations documented in the record. Further review of this resident's record documented there were no ongoing monthly/quarterly assessments or facility interventions documented to prevent further injuries from accidents/ . In an interview conducted with Residents #2 and Resident 3's Nurse Practitioner on at 2:45 PM, she stated she was familiar with Residents #2 and Resident #3's medical care at the facility. She stated it was her expectation that the facility followed-up and was aware of Resident #2's services to ensure proper care and implement interventions to prevent future accidents/ . She stated Resident #3 was initially ordered Physical and services on but encountered difficulties with insurance payment coverage which prevented the resident to presently receive these services. She stated that regardless of the resident's ability to pay for these services, the resident's present clinical need to receive Physical and	A 025		

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A 025	Continued From page 8 services was important and the facility may seek an alternative manner for the resident to receive these services. She stated that Resident #3 presently required assistance with her activities of daily living and she expected the facility staff to perform this level of personal care service for the resident to prevent future accidents/ . . . In an observation conducted on . . . . . at 3:25 PM, inside Resident #3's bedroom, there was a wheeled walker placed next to the bed and there was no other person inside the bedroom at this time. In an observation on . . . . . at 3:30 PM, Resident #3 was transferring from standing to sitting outside the dining room without using an assistive device or having any staff supervision or assistance. In an interview conducted with the resident at this time, she stated that she wasn't aware that she needed to use her wheeled walker to ambulate. In an interview conducted with the Administrator on . . . . . at 11:25 AM she stated that the facility was in process of implementing all of its new policies and procedures due to its recent change of ownership. She stated that Resident #3 waiting for Physical and . . . . . services for over 2 months was too long and she was going to expedite arranging these rehabilitation services so the resident had to wait no more. She stated the facility presently did not assess/re-assess each resident every month or every quarter to determine the individual level of care they needed, but the facility was planning to implement its "Ongoing Resident Appraisals" very soon. Class III	A 025		

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A 052	Continued From page 9	A 052		
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 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	A 052		

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A 052	Continued From page 10 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 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	A 052		

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A 052	Continued From page 11 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 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 [illegible] 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, orally advising the resident of the name and dosage of the medication 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	A 052		

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A 052	Continued From page 12 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 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. (g) 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. (h) All trained staff must adhere to the facility's . . . . control policy and procedures when assisting with the self-administration of medication.	A 052		

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A 052	Continued From page 13 This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to properly assist 2 out of 2 residents (Residents #10 and Resident #11) with self-administration of medications by not orally advising each resident of the medication names and dosages they received. The findings included: In an observation conducted on at 12:05 PM, Staff Nurse A assisted Resident #11 with the self-administration of and oral medications by giving these without orally advising the resident of the names and dosages provided. In an observation conducted on at 12:15 PM, Staff Nurse A assisted Resident #10 with the self-administration of , and oral medications by giving these without orally advising the resident of the names and dosages provided. In an interview conducted with Staff Nurse A on at 12:20 PM, she stated she was aware she did not orally advise Residents #10 and Resident #11 of the medication names and dosages before she gave them their oral medications. She stated the residents did not have a written waiver to opt out of being orally advised of the medications they received. Class III	A 052		

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A 162	Continued From page 14	A 162		
A 162	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. [illegible], 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance [illegible], 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the health care provider and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 described in rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, [illegible], or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(e), F.A.C. (f) A [illegible] record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their [illegible] recorded semi-annually.	A 162		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969358	A. BUILDING: _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BANYAN PLACE-LANTANA	1021 RIDGE RD LANTANA, FL 33462

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A 162	Continued From page 15 (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to rule 59A-36.008, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in section 429.27, F.S. (l) If the resident is an . . . recipient, a copy of the Department of Children and Families form Alternate Care Certification for , , ... ' ' ( ), CF-ES 1006, . . , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the , , of a health care surrogate, health care proxy,	A 162		

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A 162	Continued From page 16 guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in rule 59A-36.006, F.A.C. (o) The resident's . . . . . , DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to the following at the discretion of the facility: 1. A log listing the names of residents participating in this arrangement, 2. The resident demographic data required in this paragraph, 3. The health assessment described in rule 59A-36.006, F.A.C., 4. The resident's contract described in rule 59A-36.018, F.A.C.; and, 5. A health care provider's order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in rules 59A-36.020,	A 162		

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A 162	Continued From page 17 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to maintain 1 out of 12 sampled resident records (Resident #1) on the facility premises which must include the resident's health assessment (documented on AHCA Form 1823), resident care record with any applicable physician orders and the resident's contract with the facility. The findings included: Review of Resident #1's record on revealed that there was a resident sheet and observations notes, which contained general observations of when the resident was in the facility from to . In an interview conducted with the Administrator on at 11:30 AM, she stated that the facility recently underwent a change of ownership and that the previous facility owner did not provide the facility with Resident #1's complete record for review by the Agency. She stated she was in the process of requesting this record from the facility's previous ownership. In an interview conducted with the Administrator on at 10:05 AM, she stated the facility's previous owner was going to provide Resident #1's record for review. In an observation on at 10:35 AM, the facility's previous owner arrived at the facility and he possessed a file which was represented as Resident #1's record. In an interview with the facility's previous owner at this time, he stated	A 162		

Agency for Health Care Administration

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A 162	Continued From page 18 that the file that he possessed must be reviewed by the Agency while in his presence and he must have the complete file before he departed the facility. In an interview conducted with the Administrator on . . . . . at 10:40 AM, she stated that she will attempt to retrieve the file in possession by the previous owner for review by the Agency. In an observation on at 10:45 AM, the facility's previous owner departed the facility. In an interview conducted with the Administrator on at 2:20 PM, she stated the facility's previous owner had no affiliation with the facility's current ownership. She stated at this time, she was not able to retrieve Resident #1's record for review by the Agency. Class III	A 162		