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 _____	R 07/21/2022

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 revisit to the Complaint survey (#2021017291, #2021017553 & #2022004582) was conducted from to at The Residence at Dania Beach assisted living facility. The previously cited deficiencies were found uncorrected at the time of this survey.	{A 000}		
{A 079}	59A-36.010(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum staff hours per week: Number of Residents, Day Care Participants, and Respite Care Residents Staff Hours/Week 0-5 168 212 16-25 253 26-35 294 36-45 335 46-55 375 56-65 416 66-75 457 76-85 498 86-95 539 For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week. 2. Independent living residents, as referenced in subsection 59A-36.015(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for purposes of computing minimum staff hours. 3. At least one staff member who has access to facility and resident records in case of an	{A 079}		

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{A 079}	Continued From page 1	{A 079}		

emergency must be in the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility.
4. In facilities with 17 or more residents, there must be at least one staff member awake at all hours of the day and night.
5. A staff member who has completed courses in First Aid and [illegible]
( ) and holds a currently valid card documenting completion of such courses must be in the facility at all times.
a. Documentation of attendance at First Aid or courses pursuant to subsection 59A-36.011(5), F.A.C., satisfies this requirement.
b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and [illegible]
6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least [illegible] must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or manager.
7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement.
8. The administrator or manager's time may be counted for the purpose of meeting the required

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staffing hours, provided the administrator or manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule.
9. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted.
(b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in rule 59A-36.007, F.A.C.
(c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives.
(d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision and care are not being provided to residents, resident care standards described in rule 59A-36.007, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire

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{A 079}	Continued From page 3 safety authority, the agency may require additional staff when the facility fails to meet the fire safety standards described in rule chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety requirements are being met. 1. When additional staff is required above the minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 59A-36.020, 59A-36.021 or 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to have sufficient direct care staff scheduled to provide adequate supervision to meet all of the resident care and service needs.	{A 079}		

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{A 079}	Continued From page 4 The findings are: Review of the facility's "Resident Supervision/Assistance with ADLs" policy and procedures dated on [redacted], revealed that the facility "must provide care and services appropriate to the needs of residents" and "must offer personal supervision and assistance with activities of daily living as appropriate for each resident." Further review of this document revealed that that the facility staff must have "awareness of the general health, safety, and physical and emotional well-being of the resident". {Photographic evidence was obtained). Review of the "Resident Supervision Policy" dated on [redacted] revealed the following: "The Residence at Dania Beach implemented a 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. That includes an hourly check of all residents. Every caregiver assigned to a resident must sign the sheet and state where the resident is located and what the resident is doing. Any change in resident's condition must be reported to the nurse and administrator. Examples of change and condition: resident is sleeping longer than normal, refusing assistance with care, changes in skin, condition issues, ambulating, unsteady gait. The caregiver must note the resident's activity including: toileted, changed brief, shower, [redacted], oral care ambulation, eating, recreation/activity, sleeping". (Photographic evidence was obtained). Review of the facility's 2021 Fire Safety Plan on page 15, the 24-hour direct resident care staffing coverage was described to have 8 caregivers for	{A 079}		

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each of the 7:00am to 3:00pm and 3:00pm to 11:00pm shifts and 5 caregivers for the 11:00pm to 7:00am shift at all times. Further review of this Fire Safety Plan indicated that at the time of its creation, there were 97 total residents in the facility and the plan was submitted for its annual approval period by the local emergency management agency in , . Review of the facility's resident census on indicated that there were a total of 144 residents present in the facility, including 32 residents located in the memory care unit (MCU) in the 500-wing. (Photographic evidence was obtained).

Review of the facility's floor plan revealed that the facility's 100 (west), 200 (south), 300 (east) and 400 (east) wings had approximately 80 resident bedrooms and the access-controlled memory care unit (MCU), which was in the 500-wing (north), had approximately 25 resident rooms with each room having capacity for up to 2 residents. Further review of this floor plan revealed that the facility occupied approximately 2 square city blocks in area, with the following roadways at its perimeter: Stirling Road to the south, SW 1 Court to the east, SW 2 Avenue to the west and SW 1 Street to the north. Review of the facility's property appraiser's data in the county's official website www.bcpa.net, revealed that the facility's adjusted building square footage was 62,906 square in interior area. (Photographic evidence was obtained).

Review of the most recent facility resident observation and assistance logs revealed that there were no current logs to represent staff awareness of the general health, safety, and physical and emotional well-being of the residents. Further review of the resident observation and assistance logs indicated that

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{A 079}	Continued From page 6 there were staff observations only performed on , , , , and . In an interview with resident #10 on at 12:30pm, he stated that he has lived in the facility for a few months and there were usually no direct care staff members available at night in the facility. He stated that he usually went in the 200-wing hallway after 11:00pm, and he did not see any staff member for hours on end. He stated that his concern was not so much for himself but for others residents who needed more assistance than himself. Review of the facility's resident census list dated on indicated that there were a total of 144 residents in the facility, with 112 residents in the standard care side of the facility (100, 200, 300 and 400 wings) and 32 residents in the MCU (500 wing). Review of the facility's staffing work schedule provided by the human resources manager during this inspection, did not accurately reflect the current month of staffing and this schedule was labeled from to . (Photographic evidence was obtained). In an interview with the human resources manager on at 11:15am, she stated that the staffing work schedule presented for review was what was presently being used by the facility. She stated that she was aware that the dates were not accurate and it did not list every current staff member's names. She stated that since the facility was split into 2 sections, the access-controlled MCU and the standard care side, each of the daily shifts usually had more caregivers scheduled for the standard care side of the facility, which had considerably more residents. She stated that for the 7:00am to	{A 079}		

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{A 079}	Continued From page 7 3:00pm shift there were usually 5 and 3 caregivers scheduled in the standard side and MCU respectively, for the 3:00pm to 11:00pm shift there were usually 3 and 2 caregivers scheduled in the standard side and MCU respectively and for the 11:00pm to 7:00am (overnight) shift there was 1 caregiver scheduled at each of the two facility sections. She stated that she was aware that on [redacted], the caregiver (Staff R) scheduled to work in the standard side of the facility on the 11:00pm to 7:00am did not work this shift, which only left the receptionist working in this section during this shift. She stated that the receptionist (Staff Q) was not a direct care staff member and she did not know the reason why Staff R did not actually work this shift. In an interview with Resident #9's family member on [redacted] at 12:00pm, he stated that his mother lived in the facility for less than a month from [redacted] to [redacted], and that he visited her often while she was in the facility. He stated that his mother needed assistance with numerous activities of daily living through the day and night, but there was often no staff around to assist her. He stated that since his mother's mobility was compromised, she ate breakfast in her bedroom and she often had to wait until after 10:30am for her breakfast to be delivered. He stated that his mother also had to wait prolonged periods of time to get help to go to the bathroom or be groomed. He stated that he didn't see more than 1 staff member when he visited the facility in the evenings, which for a facility of such great size and with so many residents, it was very concerning. He stated that since the facility was so short-staffed, this was the main reason why he decided to move his mother out of the facility.	{A 079}		

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{A 079}	Continued From page 8 In an interview with resident #7 on at 12:15pm, she stated that she has lived in the facility for over a year and the staff was not attentive to her needs and care. She stated that there was usually no staff available to respond to any issues that may arise. She stated the air conditioning (a/c) air duct grill in her bedroom (#105) was covered in black mold-like material and the inside of her closet had an unfinished/open wall which made her room smell badly. In an observation at this time, the bedroom's a/c air duct grill presented to have black-colored mold-like material throughout and the inside closet had a wall which was not finished or sealed with drywall. (Photographic evidence was obtained). In an interview with Staff Q on at 2:20pm, she stated that she worked at the facility as a receptionist and she was not a direct care staff member. She stated that she usually worked at the facility during the 11:00pm to 7:00am shift and that she worked this shift on Friday and Saturday . She stated that when she started her shift on Saturday , she noticed that there were no caregivers working in the standard side of the facility. She stated that this was not the first time when there was no caregiver working in the standard side of the facility during the 11:00pm to 7:00am shift. She stated that this has happened a few times before. She stated that she felt that this was not safe for the residents to not have any or even one direct care staff member working during this overnight shift, when there are over 100 residents in this section of the facility. She stated that she was limited in her duties and she was assigned to the front lobby of the facility to ensure access to emergency services when needed, but the facility was way too large to not	{A 079}		

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{A 079}	Continued From page 9 have more staff members scheduled during the evening and nights shifts. In an interview with resident #11 on at 3:00pm, she stated that she has lived in the facility for a long time and the caregivers were not responsive to her needs. She stated that the caregiver staff was very low , , in the night time and that she could not count on them to assist her if she called on them. She stated that since her room was located at the end of the 300 wing and so far away from the nursing station, it may be difficult for a staff member to hear or know when she needed assistance. She stated that her room (#314) was not maintained well and the flooring was ripped apart several weeks ago, which exposed the concrete below. In an observation at this time, it was noted that the laminate flooring inside the resident's room was partially removed which exposed the concrete below the laminate flooring. (Photographic evidence was obtained) In an interview with the administrator on 1:55pm, she stated that the facility was presently operating under the 2021 Fire Safety Plan and this has not been updated. She stated that she was aware that the facility needed more direct care staffing during the night time shifts and this was presently difficult to achieve due to the generalized staffing shortage. She stated that she was not aware that there was no caregiver working on during the 11pm to 7:00am shift in the standard care side of the facility. Review of the facility staff time sheets provided on indicated the following. Review of the facility time sheets dated from to , which included all of the facility staff members with their recorded work times during this period,	{A 079}		

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{A 079}	Continued From page 10 revealed that there were no direct care staff members who worked in the facility's standard care side of the facility on [redacted] and [redacted] during the 11:00pm to 7:00am shift. In an interview with the administrator on [redacted] at 3:15pm, she stated that every caregiver was expected to log their resident observations on every shift. She stated that she could not accurately monitor every staff member's time worked in the facility until after their shift ended because reviewing their individual time sheet required her to print out the time clock recordings after the fact. She stated that the facility time clock was also presently not in optimal working order because it did not accurately record some of the times in which staff members actually worked. She stated that this was a problem which she had not resolved. (Photographic evidence was obtained). Class III	{A 079}		
{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 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	{A 152}		

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{A 152}	Continued From page 11 furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to provide a safe, clean and decent living environment for its residents. The facility failed to ensure that it maintained a pest-free environment, failed to ensure its emergency exit doorways inside the memory care unit (MCU) were unobstructed and it failed to repair and maintain existing appurtenances in resident areas. The findings are: In an observation on at 11:00am in the facility's memory care unit (MCU), it was noted the east, south and north exit doorways leading to	{A 152}		

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{A 152}	Continued From page 12 the exterior fenced areas of the MCU were obstructed with stacked tables and other furniture. It was also noted that when opening these all of these doorways, there was no audible alarm or time delay system installed, in which to continuously alert the facility staff that each doorway was opened. (Photographic evidence was obtained). In an interview with the county fire and life safety inspector on at 2:00pm, he stated that the facility was in life safety violation for having the MCU's east, south and north exit doorways leading obstructed with furniture because it impeded the exit of the building occupants shall an emergency occur. He stated that based on the residents who resided in the MCU, it was recommended that the facility had alarmed time delays installed in each of these doorways so to alert the staff that someone was exiting through the doorways. He also stated at this time, that the facility staff was required to have all keys necessary to unlock the fenced areas immediately outside of these doorways shall evacuation of the occupant was needed during an emergency. He stated that he found that the MCU staff members did not have the fence keys needed for this. In an observation on at 12:15pm inside resident # , it was noted that the air conditioning (a/c) supply vent had black, mold-like stains on its surface. During this observation, it was also noted that the interior closet wall had an unfinished area without drywall, which exposed the inside of the wall. In an interview with Resident #7 at this time, she stated that she was sure that the discoloration on the a/c vent was mold-like because it gets worse with time. She also stated that the unfinished interior closet wall	{A 152}		

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(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 152}	Continued From page 13	{A 152}		

made her room have a musty smell. (Photographic evidence was obtained).

In an observation on at 2:55pm inside resident # , it was noted that the laminated floor was removed and exposed the underlying concrete below the finished floor. During this observation it was also noted that the walls were not wholly painted and the room had missing base boards. (Photographic evidence obtained).

In an observation on at 3:05pm in resident # , the bed which was used by Resident #13 had several small dark red stains on the sheets. Further observation at this time, there were 2 dark bugs (less than inch in size) crawling inside the resident's bed sheets and there was 1 dark burg on the floor immediately next to his bed. In an interview with Resident #13 at this time he stated that the stains on his sheets were from him exterminating the bed bugs with his while he was on his bed. He stated that he has asked the facility housekeepers to change his sheets for over 2 weeks and the facility has not changed the bed sheets. He also stated that he notified the maintenance director that he had seen bed bugs inside his bed and the maintenance director gave him a "bed bug killer" spray so he could treat the bugs himself. He stated that he didn't remember the last time a pest control contractor had been inside his bed room to treat the bugs. (Photographic evidence was obtained).

Review of the facility's recent pest control contractor invoices revealed that on fifteen resident rooms, including # , were treated for bed bugs, on resident rooms in the 400 wing were treated for bed bugs, on

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 _____	R 07/21/2022

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{A 152}	Continued From page 14 . . . . . seven resident rooms, not including . . # . . , were treated for bed bugs and on five resident rooms, not including . . # . . , were treated for bed bugs. (Photographic evidence was obtained). In an interview with the Department of Health (DOH) inspector at 8:55am, he stated that he responded to the facility to inspect for bed bugs and 1 out of 2 inspected rooms he checked was (+) for live bed bugs. He stated that resident # had live bed bugs during his inspection and that the facility was cited for this. He stated that DOH previously inspected the facility for bed bugs on and . . # . . was (+) for live bed bugs. He stated that this was subsequently corrected. In an interview with the pest control contractor manager on at 11:00am, he stated that the facility presently received general and bed bug preventative pest control. He stated that he has recently received numerous calls by the facility to for all kinds of bugs, including bed bugs, and his staff responded within days after these calls were placed. He stated that about 6 months ago, the facility had an influx of residents whom likely introduced bed bugs and the facility experienced a spike in bed bug activity. He stated that he met with the facility ownership about 3 weeks ago to ramp up the bed bug specific pest control since the current process was not adequate to control the bed bugs. He is presently waiting to hear from the facility ownership to upgrade this pest control service to include a more aggressive bed bug abatement procedure. Class III	{A 152}		