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
	AL11966084	A. BUILDING: _____ B. WING _____	09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TITUSVILLE TOWERS	405 INDIAN RIVER AVENUE TITUSVILLE, FL 32796

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A 000	Initial Comments Complaint Investigation #2022008140 and a Generator Monitoring was conducted on , , and . Titusville Towers ALF had deficiencies at the time of the survey.	A 000		
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule	A 025		

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A 025	Continued From page 1 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 observations, record reviews, and interviews, the facility failed to provide care and services appropriate to meet the needs of residents accepted for admission to the facility by failing to provide adequate supervision to 2 of 7 sampled residents who smoked in their room (#6 & #11), and to 2 of 7 sampled residents who had an altercation (#7 & #9). Findings: 1. Resident #6's record revealed a facility admission date of . The resident's diagnoses were	A 025		

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A 025	Continued From page 2 [illegible] and [illegible] Resident #6's Residency Agreement, dated and signed by the resident, indicated that smoking was strictly prohibited in common areas and was allowed only in designated areas. A Smoke-Free Policy and Lease addendum was dated and signed by resident #6. A meeting notice, signed by resident #6, indicated that a meeting regarding the no-smoking policy would be held on . On at 10:25 AM, resident #6's room was found to have a strong smell of cigarettes. The resident was seen lying in bed and she wore . The facility's Assistant Manager was present and said, "As you can tell, she smokes in here. We've talked to her and talked to her. We're at the point of giving her a discharge notice but the only place for her to go is a nursing home and she's not really ready for that." She said the Manager previously removed an ashtray from the resident's room, and the next day housekeeping saw another one in there. On at 1 PM, resident #6 sat at a table in her room. A facility notice was seen on top of a table, and indicated that if residents smoked in their room, they would be evicted. The resident said the notice was given to her on that day. She said she did smoke in her room and that the facility had previously told her not to. She said based on the notice she received that day, she would no longer smoke in her room and would only smoke outside.	A 025		

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A 025	Continued From page 3 On . . . . . at 1:39 PM, the Manager said that when the Housing Authority completed a recertification on . . . . . , they found that resident #6 was smoking in her room. The Manager said that a few days following the recertification, she spoke with the resident about the findings. The Manager said she removed the resident's cigarettes and ashtray from the resident's room, but housekeeping found another ashtray in the room on the following day. The Manager said she did not document the discussion she had with the resident, and she confirmed the notice seen on the resident's table was given to her on . . . . . . Review of an email from the Housing Authority, dated , revealed that after several warnings, resident #6 continued to smoke inside. It indicated that the maintenance crew confirmed she was also smoking in the hallway and that she was advised against it many times. On at 1:50 PM, the Manager said that she believed it was during the previous week that she removed the resident's cigarettes and ashtray and told the resident that she would be periodically checking for compliance. When the Manager was asked whether the facility issued the resident a 45-Day Discharge Notice for her repeated noncompliance with the "No Smoking Policy", the Manager said "No . . . she's dying, and I hate to put her in a nursing home when she's been here since 2016." On at 1:25 PM, Caregiver H said she worked at the facility since . . . . She said she saw resident #6 smoke in her room with . . . . . and when she told the resident that it was inappropriate to do so, the resident replied that she knew that.	A 025		

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A 025	Continued From page 4 On [illegible] at 3:08 PM, Caregiver D said she worked at the facility since [illegible] and had seen resident #6 smoke in her room with [illegible] ever since that time. The caregiver said she reported what she saw to the Manager 2. Resident #11's record revealed a facility admission date of [illegible]. The resident's diagnoses were [illegible], left [illegible] disc [illegible], [illegible] type 2, [illegible] and [illegible]. A Long-Term Care Insurance Annual Assessment, dated [illegible], indicated smoking in the resident's apartment was prohibited and he was told he would receive a 45-Day Discharge Notice to vacate if he was caught smoking in his apartment again. Resident #11's Residency Agreement, dated [illegible] and signed by the resident, indicated that smoking was strictly prohibited in common areas and was allowed only in designated areas. A separate facility notice, dated [illegible] and signed by resident #11, indicated that smoking was not allowed anywhere in the building On [illegible] at 3:50 PM, resident #11 sat in a wheelchair in his room. His room had a strong smell of cigarettes. He held an unlit cigarette between two [illegible] and two ashtrays on a table contained cigarette butts. A can of lighter fluid was seen on the floor near the table. The resident said he used it to fill his lighter. The Assistant Manager was present and said the resident did smoke in his room. The resident said he smoked in his room and said, "You can evict me if you want 'cause I've been trying to leave here anyway. I'm gonna do it till they get me outta here."	A 025		

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A 025	Continued From page 5 On 1:15 PM, Nurse F said she worked at the facility for one month and said that during that time, she saw resident #11 smoking in his room. On at 1:20 PM, Caregiver G said she worked at the facility for one year and that during that time, she'd seen both residents #6 and #11 smoke in their rooms on multiple occasions. She said that although she discussed the risks with resident #6, the resident did not care. On at 4:42 PM, the Manager said that she learned approximately two months prior that resident #11 smoked in his room. She said she learned approximately one month prior that resident #6 smoked in her room with the use of 3. Resident #7's record revealed a facility admission date of . The resident's diagnoses were , and Resident #9's record revealed a facility admission date of . The resident's diagnoses were without behavioral disturbances, , and dependency. A facility report indicated that on at approximately 9 PM, resident #7 reported to Caregiver A that resident #9 was drunk and trying to enter his room. Caregiver A informed Caregiver D of the situation. Resident #7 returned upstairs and when he returned downstairs at approximately 9:20 PM, he had a black and on his . He told Caregiver A that resident #9 started a fight with him and punched him in the and as a result, resident #7	A 025		

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punched resident #9 in the . . . . Caregiver D checked on resident #9 and saw the resident was . . . . . , so she called 911. At approximately 9:40 PM, law enforcement and emergency medical services arrived. Resident #9 was taken to the hospital. Resident #7 refused to go to the hospital and was given an ice pack for his . , . . The facility's corrective action was that resident #7 was removed from the altercation and to the safety of his room.

A law enforcement involuntary examination report indicated that on . . . . . , resident #9 had . . . . emitting from his person, and that he caused harm to another resident and to himself. He walked into another resident's room trying to pick a fight which caused him to sustain injuries to his . He was a danger to himself and others due to wanting to fight people. He was unable to complete sentences and had difficulty walking due to his level of intoxication.

On . . . . at 10:55 AM, resident #7 sat at a table in his room. When asked about the altercation he had with another male resident, he said a man came into his room so he told the man to get out and that if he returned, he would hit him. Resident #7 said the man left without further incident and that a physical altercation between the two of them did not occur.

On at 11:40 AM, resident #9 was seen walking around the facility. When asked about the altercation he had with another male resident, he said he did not go into anyone's room and that a man just came out and started with him for no reason. He said a physical altercation between the two of them did not occur.

On at 3:08 P.M., Caregiver D said that

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A 025	Continued From page 7 Caregiver A did not tell her that resident #7 reported that resident #9 was trying to come into his room and that she first learned of it when it was reported that resident #7 had on his . . . . The Caregiver said that resident #7 told her that another resident him, and he had to protect himself. She said resident #7 sustained a black . She said she then saw resident #9 on the elevator and . . . . was coming from the of his . She said his speech was slurred, he was agitated, and while pointing at her, he walked towards her and tried to grab her. She said other staff told her that resident #9 had been drinking all day however, she did not see him drinking. On . . . . . at 1:49 PM, Caregiver A said that on at approximately 8 PM resident #7 came to the ground floor and told her that resident #9 was going into his room and that resident #9 needed to leave him alone. Caregiver A said she told resident #7 that she would tell his Caregiver, which was Caregiver D. Caregiver A then rode the elevator with resident #7 and they parted ways. The Caregiver said that at approximately 8:15 PM, she saw Caregiver D and told her what resident #7 reported. Caregiver A said it was immediately afterwards that resident #7 came downstairs and she saw he had a black . and on his . She said that resident #7 said that resident #9 hit him with something. She said that resident #9 drank . . and had a history of going into other resident's rooms. On . . . . . at 4:42 PM, the Manager said that following the altercation between residents #7 and #9, she spoke with resident #9's daughter, the resident, and staff. The Manager believed nothing could have been done to prevent the altercation. When asked why Caregiver A did not	A 025		

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A 025	Continued From page 8 accompany resident #7 to his room when he told her that resident #9 was coming into his room, the Manager said she did not discuss that with the Caregiver. She said resident #9 did drink . . . . . prior to the altercation but his drinking did not cause any issues. Class II	A 025		
A 030 SS=D	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida . . . . Hotline,	A 030		

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A 030	Continued From page 9 1(800)96- . . . . or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident . . . . , neglect, and . ; 6. Administrative and housekeeping schedules and requirements; 7. . . . . control, sanitation, and standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical . (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which	A 030		

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A 030	Continued From page 10 residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's	A 030		

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A 030	Continued From page 11 representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care ..., and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally ..., the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal	A 030		

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A 030	Continued From page 12	A 030		

representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction.
(l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups.
(2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that

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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 030	Continued From page 13 retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder . . . . Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated . . . , . . . or . . . , ... under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to honor the rights of 1 of 17 sampled residents by failing to treat the resident with consideration, respect, and with the need for privacy (#10). Findings:	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11966084	A. BUILDING: _____ B. WING _____	09/01/2022

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A 030	Continued From page 14 Resident #10's record revealed a facility admission date of [redacted]. The resident's diagnoses were [redacted], and [redacted]. A facility note dated [redacted] at 1:09 AM indicated the resident pressed her call pendant from her bathroom. She was found on the floor beside the toilet. She said her [redacted] got caught between the bars next to the toilet, which caused her to [redacted]. 911 was called and she was transported to the hospital. A facility note dated [redacted] at 2 PM indicated the resident's family reported that the resident's health had declined and that she would remain at the long-term care facility. An email, dated [redacted], from the facility's Business Office Manager and to the resident's family indicated the family had until [redacted] to remove the resident's belongings from her room. A 30-Day Vacate notice, signed by the resident's family member on [redacted], indicated the notice would take effect on the first day of the next month. Review of a facility incident report revealed that on [redacted], the resident's family member showed the facility manager video footage from the resident's room that showed Social Worker (SW) E going through the resident's belongings without permission from the family to do so. The facility's corrective action was to place SW E on leave pending an investigation. The SW's employment was terminated on [redacted]. A new policy was	A 030		

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A 030	Continued From page 15 implemented for securing resident apartments. On . . . . . at 4:42 PM, the Manager said that she too went into the resident's room during the resident's hospitalization to remove items that she said belonged to the facility, such as gloves, wipes, and lotions. The Manager said she also went in for medical equipment pick-up, to adjust the room temperature, and to look for a pendant as asked to do so by the family. The Manager said she also went in to look at the floor plan for a new move-in and to conduct a tour with prospective new residents. She said that other than looking for the pendant, she did not obtain permission from the resident's family to enter the room. Class III	A 030		