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
	AL11969444	A. BUILDING: _____ B. WING _____	R 02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA AT PARKSQUARE (THE)	2940 NE 207 STREET AVENTURA, FL 33180

(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 165} SS=E	429.23(&) FS Risk Mgmt & QA 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. ; 2. or , damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency's online portal, or if the portal is offline, by electronic mail, a	{A 165}		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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{A 165}	Continued From page 1	{A 165}		

preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident.
(4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident.
(6) , neglect, or , must be reported to the Department of Children and Families as required under chapter 415.
(7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply.
(8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report

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{A 165}	Continued From page 2 this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to file an adverse incident report in a timely manner within one (1) business day as required for Resident #58. The facility failed to report and neglect including , regarding Residents #4 and #108 to the Department of Children and Families (DCF). Findings: 1) A review of the Adverse Incident report (AIRS) database revealed Resident #108 had a on and was transported to the hospital but a preliminary report was made on at 9:48 AM. 2) A review of the resident record revealed a complaint that on , Resident #20's family stated that the resident was placed in a shower by Staff AB (caregiver) as a punishment for having soiled himself. Further review of the resident and facility records found no	{A 165}		

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{A 165}	Continued From page 3 documentation of an investigation. There was no documentation that the facility reported the incident to DCF. A review of Staff AS (Caregiver) Disciplinary Action form dated showed that she was given a verbal warning and education for yelling and leaving Resident #87 in her apartment naked for a long time. There was no documentation that the facility reported this incident to DCF. A review of Staff AS (Caregiver) Disciplinary Action form dated showed that she left Resident #4 on the edge of her bed with her bra around her while she (Staff AS) sat in the common area. There was no documentation that the facility reported this incident to DCF. Interviewed on at 10:26 AM when asked who saw Resident #4 seated at the edge of the bed with her bra around her , the Assistant Director of Nursing stated, "I actually walked in and saw her with the bra around her We counseled Staff AS." The Assistant Director of Nursing stated further that she did not make a call to DCF regarding Resident #4. Interviewed on at 10:26 AM when asked if the cases of and neglect were reported to DCF, the Administrator stated that a thorough investigation was conducted and stated that her definition of was and neglect. The administrator stated further that she did report it to DCF but all the residents involved were interviewed and that and neglect was discussed during the shift meetings. Uncorrected	{A 165}		

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{A 165}	Continued From page 4 Class III	{A 165}		
{A 000}	Initial Comments A third revisit to a complaint investigation (2022013978, 2022014228, 2022018178, 2022018517) was conducted at Plaza at Parksquare from [redacted]. Deficiencies were identified at the time of the survey.	{A 000}		
{A 010} SS=G	429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements; examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who	{A 010}		

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{A 010}	Continued From page 5 requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care. (d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to: a. Move, turn, or reposition without total physical assistance; b. Transfer to a chair or wheelchair without total physical assistance; or c. Sit safely in a chair or wheelchair without personal assistance or a physical . 2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days. 3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days. (2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney	{A 010}		

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{A 010}	Continued From page 6 in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department. (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to- medical examination by a health care practitioner at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S. (b) A resident requiring care of a , may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care,	{A 010}		

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{A 010}	Continued From page 7	{A 010}		

or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care practitioner,
2. The condition is documented in the resident's record; and,
3. If the resident's condition fails to improve within 30 days, as documented by a health care practitioner, the resident must be discharged from the facility.
(c) A , ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met:
1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need;
2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency;
3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and,
4. Documentation of the requirements of this paragraph is maintained in the resident's file.
(d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times.
(e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license.
(f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily

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{A 010}	Continued From page 8 living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure the appropriateness of continued residency for two out of 119 sampled residents (Resident #4, #108). Findings include: 1) On at 8:57 AM observed Director of Resident Care, crush Resident #4's tablets, mix them into a cup of apple sauce and feed them to the resident. Observation on at 9:17 AM showed Staff V, CNA feeding Resident #4 her breakfast. A review of Resident #4's health assessment dated showed a medical history and diagnoses of , atherosclerotic , , and . The resident needed supervision with eating and assistance with ambulation, bathing, , grooming, toileting, transferring and self-administration of medication. The health assessment indicated that the resident needed precautions. During an interview on at 9:05 AM, Assistant Director of Resident Care, stated, "She is not like this all the time. This is the 1st time I've seen [Resident #4] like this."	{A 010}		

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{A 010}	Continued From page 9 A review of Resident #4's progress notes dated showed, "Received a report that resident has been agitated in late afternoons, attempting to get off the wheelchair unassisted." A review of Resident #4's record showed that she had a history of multiple . , some with injuries including of the , and and the latest leading to hospitalization on . On at 10:46 AM, when asked whether the facility evaluated Resident #4 for appropriateness of continued residency, Director of Resident Care, "I don't feel like [Resident #4] inability to take her meds is a change in condition, sometimes she just needs help." 2) A review of an incident report dated . . . showed at 11:20 PM, "[Resident#108] called and found on the floor. He stated he was getting up from the chair. He lost balance; encourage him to stay in bed and call for help and use his walker." A review of a second incident report dated showed at 8 PM, "Resident states that while in the shower he slipped and . . He did not have a pendant at the time." A review of a third incident report dated . . . . . showed at 8 PM, "Resident noted sitting in nursing office stated, 'I was on the treadmill, and it didn't stop when I wanted to, I tried to get off and .' A review of a fourth incident report dated . . . . . showed at 5:45 AM, Resident #108 stated to staff that he slipped in the bathroom. In an interview on at 11:11 AM, Staff	{A 010}		

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{A 010}	Continued From page 10 AR, Certified Nursing Assistant, stated, "on , I was conducting my final rounds. [Resident #108] was lying in the middle of the bed sleeping at 5 AM. He told me he had been lying on the floor all night. I told him that was not possible because he was on his bed. I then checked the bathroom, and there was no indication of a . He was found on the floor by his daughter on the next shift around 7 AM." On at 2:14 PM, Resident #108's son stated, "My father suffered severe , which resulted in surgery from the he had on . My sister found him on the floor between 7 AM- 8 AM. He spent seven to eight hours on the floor." Interviewed on at 12:31 AM, when asked about Resident #108's on , Staff AM, Administrator stated, "When we interviewed [Staff AR], she said when she was doing her rounds at around 5:45 AM, she found the resident in the middle of the bed. He couldn't have because he can't get up from the floor without assistance." A review of Resident #108's health assessment dated showed medical diagnoses and a history of Prostatic Hyperplasia, , Dyslipidemia, , diverticulosis, , and tremor. The resident was independent in ambulation, bathing, , eating, grooming, toileting, transferring and assistance with self-administration of medication. The health assessment indicated that the resident had no precautions. On at 11:58 PM, when asked when the facility looks at if residents are appropriate for	{A 010}		

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{A 010}	Continued From page 11 continued residency, Staff AM stated, "After three , we look into continued residency. He refused to go to rehab. He is of sound mind, so he can make his own decisions." A review of Resident #108's monthly status summary, last completed on , indicated no third-party services such as , , or any comments in the section about whether changes occurred or decline in status and what steps were taken. The facility noted that Resident #108 was appropriate for continued residency. Uncorrected Class II	{A 010}		
{A 025} SS=L	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	{A 025}		

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{A 025}	Continued From page 12 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 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 record review, and interview, the facility failed to provide adequate supervision as appropriate for each resident to ensure	{A 025}		

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{A 025}	Continued From page 13 awareness of the general health, safety, physical and emotional well-being for 9 out of 119 sampled residents (Residents #19, 24, 35, 41, 51, 55, 79, 86, 108). Resident #108 suffered a hematoma after he and reported being left on the floor for over seven hours. Resident #51 sustained a right , and Resident #55 sustained a ninth after a . Resident #35 sustained a , and Residents #19 and #86 sustained at multiple places on their bodies. Resident #24 suffered an injury to the right ringer , and Residents #41 and #79 were transferred to the hospital after falling at the facility. Findings include: A review of an incident report dated at 11:20 PM showed, Resident #108 contacted staff requesting assistance. Upon the staff's arrival, the resident was found on the floor. He stated that as he got up from the chair, he lost his balance and . The staff noted that the resident had no apparent injuries. A review of a second incident report dated showed Resident #108 slipped and while in the shower. A review of Resident #108's progress notes dated showed, "Resident reported two days ago he in the shower. Denies , at this time. Noted with superficial to the right ." A review of a third incident report dated showed at 8 PM that the resident informed staff in the Wellness Center that he off the treadmill. Resident #108 stated, "I was on the treadmill, and it didn't stop when I wanted to. I tried to get off and ." The resident sustained	{A 025}		

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{A 025}	Continued From page 14 . . . . . on his . . . . . extensions. A review of a fourth incident report dated at 5:45 AM Resident #108 stated to staff that he slipped in the bathroom. Staff noted that the resident sustained to the and . . . . A review of Resident #108's progress notes dated showed "late entry from . Received report from [Staff AR, Certified Nursing Assistant (CNA)] who stated while doing rounds, resident was noted in bed and stated he slipped in the bathroom. Denies , and doesn't know how he ended up in the bed. Staff reports resident has no . The resident was then given a pendant and placed by the bedside as per staff. Received a call from staff that resident was transferred to hospital by the family for evaluation." A review of the facility's communication log dated . . . . . showed during the dayshift (6 AM-2:30 PM), "Resident was found on the floor stated he was there since last night. AMR (American Medical Response) was called but the son told us to cancel it and we will bring his father to the hospital." During an interview on at 11:26 AM, Staff AF, Medication Technician stated, "Resident #108 on /202; it had to be a Friday or Saturday morning. Nobody went to his room. [Staff AG, Assistant Director of Resident Care] called me to activate a new pendant. [Staff AR] was working overnight. She did not check the room. His daughter found him on the floor. According to the Resident, he asked [Staff AR] to help him, and she stated that she was going to get some help and never came ."	{A 025}		

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{A 025}	Continued From page 15 On at 11:14 AM, Resident #108's daughter stated she found her father on the floor the morning of . Her father told her that he pushed the pendant, and someone told him they would return, but they never returned. She further stated, "When I found him on the floor, I ran to the second floor to find somebody. I found [nurse] with home health. There was no staff to help me. I did what I thought was the best thing for my father. I needed help." A review of Resident #108's hospital record dated showed a "History of Present Illness" presenting after a mechanical this morning at his nursing home. States he was in the shower when he lost his balance and . Attempted to use his emergency line but was unsuccessful in reaching help. Downtime 7 hours until he was found by nursing home staff. Presented to the outside of hospital for evaluation via his son. This is not the first episode of its kind; in 2021, the patient was walking out of an elevator when he lost his balance and . In 2022, the patient was in his bathtub when he lost his balance again and ." The resident sustained a hematoma. A review of Resident #108's health assessment dated showed medical diagnoses and a history of Prostatic Hyperplasia, , Dyslipidemia, , diverticulosis, , and tremor. The resident was independent in ambulation, bathing, , eating, grooming, toileting, transferring and assistance with self-administration of medication. The health assessment indicated that the resident had no precautions.	{A 025}		

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{A 025}	Continued From page 16 A review of Resident #108's records showed no documentation of the resident being reassessed after his . . . There was no documentation of an updated health assessment. A review of Resident #108's record showed a prescription dated . . . . . for , , ... Further review of Resident #108's records showed no documentation of the resident receiving , , . There was no documentation that the physician was contacted for follow-up care or for recommendations to prevent the reoccurrence of . . . During an interview on . . . . . at 11:58 PM, when asked what measures were put in place to prevent Resident #108 from falling, Staff AM, Administrator stated "We educated him on using his walker and using his pendant. He refused to do rehab." 2) A review of an incident report dated 11/30/2022 showed at 12:45 PM, Resident #19's wife informed staff that her husband while walking to the dining room with his walker. Staff noted that the resident had two , one on the right arm and one on the right . . A review of the facility's 24-hour communication log dated showed during the dayshift shift (6 AM- 2:30 PM), "Resident had a . this morning while he was walking outside with his PDA (private duty aide). He was accompanied to [hospital] by his wife." A review of Resident #19's progress notes dated showed, "Received a call from HH (home health) nurse who stated it was reported	{A 025}		

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{A 025}	Continued From page 17	{A 025}		

that resident had [illegible] in the common area outside patio and received large [illegible] to the right arm and noted fluid to the area underneath. Staff sent resident to hospital for evaluation."

A review of Resident #19's progress notes showed that the resident had a prior [illegible] on [illegible], where he sustained a large [illegible] to the left arm.

A review of Resident #19's health assessment dated [illegible] showed medical diagnoses and a history of muscular [illegible], prior [illegible], sleep [illegible], and [illegible]. The resident was independent in eating and needed supervision with ambulation, bathing, [illegible], grooming, toileting, transferring and assistance with self-administration of medication. The health assessment indicated that the resident needed [illegible] precautions.

A review of the facility's policy on how to manage/prevent [illegible] showed that the residents would be monitored "to evaluate the effectiveness of intervention in reducing [illegible] and/or [illegible] risk and to decide what to do next if interventions are ineffective in reducing risk."

A review of Resident #19's record showed no documentation of the physician being contacted or recommendations to prevent the reoccurrence of [illegible].

3) A review of Resident #24's progress notes dated [illegible] showed, "On [illegible], resident stated that she [illegible] while walking toward her table. Resident complained of [illegible] in the ring [illegible]. (Emergency Medical Services) was called. The resident was transported to [hospital]."

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{A 025}	Continued From page 18 A review of hospital record dated showed a 'History of Present Illness' stating "female who presents to the ED (emergency department) for . The patient tripped over something, causing her to on her butt. She reports right fourth- , . Pain is intermittent, worsened to touch and movement." A review of Resident #24's record showed she had a prior on at the facility. A review of Resident #24's health assessment dated showed medical diagnoses and a history of , , , , history of , and an . The resident was independent with ambulation and transferring and needed supervision with bathing, , eating, grooming, toileting and assistance with self-administration of medication. The health assessment indicated that the resident had no precautions. A review of Resident #24's records showed no documentation of the resident being reassessed after her . 4) A review of the facility's incident log revealed that Resident #35 twice between and . A review of an incident report dated showed at around 11:35 AM, Resident #35's son contacted the front desk for assistance. Upon arrival, the resident was found in her bedroom closet. When asked how she , Resident #35 stated she tripped and . She sustained a to the left side of her and to her and elbows. A review of Resident #35's progress notes dated showed, "received a report that resident was in her apartment accompanied by son when she decided to go into the closet. She	{A 025}		

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{A 025}	Continued From page 19 was holding on to a bar attached to a portable clothes hanger; it got loose, and she in the closet, hitting the left side of the top of her on the corner of the wall in the walk-in closet. Staff noted the resident holding a large towel, putting pressure on a large on the . 911 was activated, and the resident was transferred to the unit at [hospital]." A review of Resident #35's hospital record dated showed a 'History of Present Illness' stating "patient who presents to the ED (emergency department) today for concerns of HS (suppurativa), LOC (loss of), +AC ( ). States that approximately 1 hour prior, she in her closet, hitting her on the ground. Was able to ambulate immediately afterwards; 911 was called due to and . Obvious grossly 10 cm to the patient's left parietal , which has some slow oozing/ ." A review of Resident #35's health assessment dated showed medical diagnoses and a history of , , and . The resident was independent in eating, and toileting and needed supervision with ambulation, bathing, transferring and assistance with self-administration of medication. The health assessment also indicated that the resident had precautions. 5) A review of the facility's incident log revealed that Resident #41 twice between and . A review of an incident report dated	{A 025}		

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{A 025}	Continued From page 20 showed at 5:40 PM, Resident #41 contacted staff to inform them she needed assistance. Upon arrival, staff found the resident on the floor. A review of Resident #41's progress notes dated showed, "Receive a report that resident was noted on floor. Stated had a , episode while ambulating, lost balance and . 911 was called, and resident was transported to [hospital]." A review of hospital record dated showed a 'History of Present Illness' stating ", female presents from ALF after slip and . Reports that she possibly slipped and into her and was unable to get up, so (emergency medical services) was called to the facility. Complaining of low ." A review of Resident #14's health assessment dated showed medical diagnoses and a history of , , acute injury and , . The resident was independent with eating and needed supervision with , grooming, toileting and assistance with ambulation, bathing and self-administration of medication. The health assessment indicated that the resident had precautions. 6) A review of an incident report dated at 11:20 AM showed Resident #51 pushed his call pendant for assistance. Upon arrival, the resident was found on the floor. Resident #51 stated he was going to the bathroom when he slipped and . No injuries were noted. A review of a second incident report dated showed at noon," Upon checking on resident, I found him on the floor. The resident stated he hit his . 911 was called to evaluate the resident. Resident refused hospital." A review of a third incident report dated at 2:30 AM showed that Resident #51	{A 025}		

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{A 025}	Continued From page 21 was found on the floor with . . . . . on his right . The paramedics were called and deemed the resident stable. In an interview on . . . . . at 11:13 AM, Staff AR stated, "When [Resident #51] , the CNA (Certified Nursing Assistant) called me to assist her; he had on his right arm. We called 911, and they came and controlled the . . . . . and did an assessment." A review of the adverse incident report filed on . . . . . showed on . . . . . at 2:30 AM, Staff AR, Medication Technician, was contacted to assist Resident #51 as he was on the floor. The resident was noted with on his right arm. Paramedics were called, and when they arrived, they dressed the resident's and deemed him stable. At 8 AM, during rounds, Staff I, Medication Technician, observed Resident #51 with a bump on his . . . . and a change in his change behavior. 911 was called, and the resident was transferred to the hospital. On , Resident #51's daughter contacted the facility to report that the hospital advised that her father had a "cracked ,". A review of Resident #51's health assessment dated . . . . . showed medical diagnoses and a history of 's , and , . . . The resident was independent in eating and needed supervision with ambulation, grooming, toileting and transferring, and assistance with self-administration of medication. The health assessment indicated that the resident had precautions. A review of hospital record dated 11/26/2022 revealed that Resident #51 sustained a right , , hematoma and an	{A 025}		

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{A 025}	Continued From page 22 angulated . . . . of the right . . . . . . During an interview on . . . . . at 10:20 AM, Resident #51's daughter stated, "They called me that day around 3 AM. He is now in rehab after the surgery. When he before nothing happened and he wasn't sent to the hospital." 7) A review of Resident #55's progress notes dated showed, "On around 5:40 PM, resident was found sitting on the floor. She stated that she as she was getting up from the chair to reach out for her walker. She also said that she hit her left side and her . . . . . She refused to go to the hospital while rescue was called to assess her." A review of Resident #55's record showed a prescription dated . . . . . for an , of the left , , and , due to , . A review of the facility's 24-hour communication log dated . . . . . showed during evening shift (2 PM- 10:30 PM), " , result is . 9th . . . . . " A review of Resident #55's health assessment dated showed medical diagnoses and a history of . . . . . , ... , , , , , and . . . . . , ... The resident was independent in eating, grooming and toileting and needed supervision with ambulation, bathing, , transferring, and assistance with self-administration of medication. The health assessment indicated that the resident had precautions. A review of incident report dated . . . . . at 7:30 PM showed, "Upon making rounds,	{A 025}		

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{A 025}	Continued From page 23 [Resident #55] was noted on the kitchen floor down shouting for help in the kitchen area. She complained of , in the left and and was noted with to the left and right . 911 was called, and the resident was transported to [hospital]." In an interview on at 10:44 AM, Staff Y, Medication Technician, stated Resident #55 was currently at rehab after she and sustained a . A review of the agency's adverse incident database showed Resident #55's and injury were not reported. 8) A review of the facility's incident log revealed that Resident #79 twice between and . A review of an incident report dated showed at around 8:35 AM, "Resident called for assistance, and the call was answered by wellness assistant. The resident was found sitting in her chair in the living room. The resident stated that she in her closet while trying to pick up clothes standing on her . She and crawled to get up. Resident denies any , ." A review of Resident #79's health assessment dated /023 showed medical diagnoses and a history of , type 2, , and . The resident was independent in eating and and needed supervision with ambulation, bathing, toileting, transferring, and assistance with self-administration of medication. The health assessment indicated that the resident had	{A 025}		

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{A 025}	Continued From page 24 precautions. In an interview on at 6 AM, Staff AG, Assistant Director of Resident Care, stated [Resident #79] was hospitalized for -related issues. On at 1:37 PM, Resident #79's daughter stated her mother was hospitalized due to a at the facility. A review of Resident #79's hospital record dated showed a 'Hospital Course' stating "female who presents to the Emergency Department with a chief complaint of . Patient has been experiencing a productive , low-grade temperatures, and increased over the past two days. This morning, she stood up from bed, became , bumped her , and landed on her left flank. The daughter has a video of the on her phone via ring camera in the room." A review of Resident #79's progress notes showed no documentation of the resident's . A review of the facility's policy on staff response to showed staff would "evaluate and monitor resident, investigate and record circumstances, resident outcome and staff response." A review of Resident #79's record showed no documentation of any investigation or interventions for the resident's on . There was no documentation that the physician was contacted for recommendations to prevent the reoccurrence of . 9) A review of the facility's incident log revealed that Resident #86 three times from months	{A 025}		

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{A 025}	Continued From page 25 through . A review of the facility's incident report dated at 5:01 PM showed, "Resident found the floor next to her bed. Resident stated, 'I was trying to help.' No , or other injuries were noted. Resident verbalized she has no ." A review of Resident #86's record showed a prescription dated ..... for home health skilled nursing to cleanse to . In an interview on at 12:11 AM, when asked how Resident #86 got the on her , Staff AN, Director of Resident Care, stated, "Sometimes the doctor just writes that. She could've had ." A review of the primary care provider's notes dated showed "slip and at ALF with to .. Needs for balance retraining." A review of Resident #86's record showed no documentation of the resident receiving . A review of Resident #86's progress notes showed no documentation of the Resident's . On at 12:14 AM, when asked if Resident #86 had in , Staff AM, Administrator stated, "No, her must have been from her on ." When told that the facility noted that Resident #86 sustained no injuries from the , Staff AM, Administrator, stated, "I have to look into that."	{A 025}		

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{A 025}	Continued From page 26 A review of a second incident report dated showed at 7:30 AM, "Resident was found in a sitting position on the floor. No noted." A review of the facility's 24-hour communication log dated showed during the dayshift (6 AM-2:30 PM), "Resident was found on the floor sitting trying to remove her diaper. She has been checked everything is ok. Her son aware of the incident and refused to send to the hospital." A review of Resident #86's progress notes showed no documentation of the resident's . A review of Resident #86's health assessment dated showed medical diagnoses and a history of 's , , and , and . The resident was independent in eating and needed supervision with grooming and assistance with ambulation, bathing, , toileting, transferring and self-administration of medication. The health assessment indicated that the resident had no precautions. A review of Resident #86's records showed no documentation of the resident being reassessed after her . A review of Resident #86's interventions in place for on and were adequate or additional lighting, medication evaluation and adjustments. A review of the facility's policy on how to manage/prevent showed that the residents would be monitored "to evaluate the effectiveness of intervention in reducing and/or risk and	{A 025}		

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PLAZA AT PARKSQUARE (THE)	2940 NE 207 STREET AVENTURA, FL 33180

(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 025}	Continued From page 27 to decide what to do next if interventions are ineffective in reducing risk." A review of Resident #86's records showed no documentation of the facility's evaluation of the effectiveness of the resident's interventions nor a decision of what would be done next as the Resident again after interventions were put into place on . Review of interventions for the residents who have at the facility showed that none of them needed "managed risk agreements". On at 12:16 AM, when asked what a managed risk agreement was, Staff AM, Administrator stated, "We don't have that here. We don't have a team of nurses to review the resident's file and to create a care plan or to review whether to determine about continued residency." Uncorrected Class I	{A 025}		
{A 027} SS=J	59A-36.007(3) FAC Resident Care - Arrangement for Health Care (3) ARRANGEMENT FOR HEALTH CARE. In order to facilitate resident access to health care as needed, the facility must: (a) Assist residents in making and remind residents about scheduled for medical, dental, nursing, or mental health services. (b) Provide transportation to needed medical, dental, nursing or mental health services, or arrange for transportation through family and friends, volunteers, taxi cabs, public buses, and	{A 027}		

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{A 027}	Continued From page 28 agencies providing transportation. (c) The facility may not require residents to receive services from a [illegible] health care provider. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to arrange for adequate care for one of 119 residents, (Resident #53) for at least six weeks prior to her [illegible]. The resident [illegible] at the facility, was hospitalized, and [illegible] days after the incident. Before her [illegible], she had often refused medications, and had been found [illegible], in the building disoriented and disrobed. The facility failed to inform or coordinate with her medical providers regarding needed care for these changes in her condition. Findings: A review of Resident #53 record revealed she had a [illegible] at the facility on [illegible] and was taken to the hospital. Further review of the record revealed the resident had changes of condition for over 60 days that required medical intervention and there was no documentation that she received it. On [illegible], while at the hospital, the resident [illegible]. Review of Resident #53's hospital record showed she arrived to the hospital on [illegible], at 7:20 PM, with an admission at 10:52 PM. The record stated "The principal admitting diagnosis/reason for visit - [illegible] requiring multiple medications, [illegible] presenting for unwitnessed [illegible] at care facility. Patient was alert and oriented X1 and had no recollection of the [illegible] and stated she had no [illegible] but has a noticeable large hematoma on the left [illegible] aspect of her [illegible]. Unclear if	{A 027}		

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{A 027}	Continued From page 29	{A 027}		

patient lost [redacted] as patient's baseline was untrustworthy. Patient was awake alert and followed commands and was moving all extremities without issue. Patient was complaining of [redacted] on palpation. Chief complaint - [redacted], unknown reason for [redacted] injury, [redacted]. Verbal response - [redacted] opening - Spontaneous. General appearance - Mildly agitated, [redacted]. Normocephalic, large firm hematoma on the [redacted] aspect of the left parietal region, mils [redacted] changes, no active [redacted]. - Tender palpation of [redacted], placed in c-collar. - CT [redacted], without contrast - Left parietal [redacted]/hematoma. No underlying [redacted]. No evidence of acute infarct, intraparenchymal [redacted] or extra axial collection. Patient was persistently agitated, actively trying to get out of bed and remove C collar. 1mg [redacted] was added. All [redacted] were negative for acute [redacted] or [redacted]. Notes on [redacted] showed patient came to the hospital secondary to [redacted], less responsive than usual. The patient had a [redacted] backwards resulting to a [redacted], hematoma. The patient had an unwitnessed at her care facility. Assessment and plan - Patient evaluated by the critical care team and continued to be monitored at the hospital. The patient had hyponatremia and was monitored. A Nephrologist was requested to evaluate. An with [redacted] was prescribed. Further recommendations were per clinical course and the patient's response to treatment. Sedating medications requested to be limited."

On [redacted], at 12:34 PM, during a phone interview with Staff AP (Medication Technician), the staff stated, "She was declining; she was on the 6th floor, but they would send her

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{A 027}	Continued From page 30 every day to the 3rd floor where memory care is for precautions. I was there that day, and I asked her not to get up by herself after she finished eating, but she still did, , and hit her with the floor; the rescue came right away, and they asked for a listing of her medications. She was not , she was awake and wanted to get up, but we told her she could not, and we put something under her to make her comfortable. I heard she . The incident happened after 6:00 pm." On , at 1:59 PM, during a phone interview with Resident #53's family members regarding the resident's care and , the family meber stated she did not know what happened. She said she received a call from the facility stating Resident #53 had and that the staff were sending her to the hospital for observation; she had a bump on her . The family member added, "I had friends and family that would take turns to go and see her in the mornings and afternoons, not during the night. That day before they left, my family members asked the staff to take care of her. When I went to see her at the hospital, all her left side of her , her was ; she was agitated, screaming, and yelling. She had another ; a resident grabbed her by her arm, and the next thing you know, she was on the floor; this happened maybe a couple of months ago. The doctor's , , on that day was for a follow up because of her arm, I don't remember the results. The facility had an order for hospice on . On , I had a meeting with all directors for memory care, she was returning from the hospital with hospice care. In , they charged me extra for additional care. She on Wednesday at 12:10 am. My friends would take her out, but they would see	{A 027}		

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{A 027}	Continued From page 31	{A 027}		

medications on the floor, or on the bed; she was not taking her medications correctly; I mentioned it to them, I went to the nurse station on the second floor, but they told me, "We'll try." They changed staff all the time, I remember Staff B, and AG."

On , at 8:06 PM, Assistant Director of Resident Care) was asked where the documentation was stating that medications were found on the resident's bed, or on the apartment's floor, "I was never aware of any medication that was left without taking it, neither from any of the staff or the family." She further stated that the Medication Technician should have reported these occurrences to her so that the resident could have received medical follow up. In reference to the resident going every day to the memory care unit for supervision, Staff AG stated, "We did not document that." Also, in reference to an done at 2:30 PM, the same day of the , Staff AG stated, "I don't know, Staff should know, I was not working with this resident. I know it is not documented."

During a second interview at the facility on at 8:15 PM, Staff AP stated that Resident #53 'sometimes 'trashed' her whole room, pooped on the floor, tore off her adult brief. On one occasion in , she stated the resident tore up her mattress .' She further stated that the resident often talked, but made no sense, and would then take off the adult brief and walk around. A review of the resident record found no documentation of the resident trashing her unit or removing her adult brief, defecating in, or leaving the unit.

On , at 4:14 PM, during a phone interview with Resident #53's friend and personal

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{A 027}	Continued From page 32 aide, she stated, "I used to go Mondays and Fridays from 9 am to 3 pm and would watch lunch. That day ( ) I left before she . . I would take [Resident #53] to the 3rd floor at the memory care unit before I would leave so she would not be by herself, and for them to keep watching her. That day she was very sleepy, and I asked them what happened because that was not normal, but they did not know. That day in the morning she had a video call with her due to her retaining liquid, and he saw her very sleepy. When we finished the video call, her daughter went to the nurse station to request her medications. At her room, I would get her medications from the carpet; the first time, I put them on the nightstand, and let the second floor know; they would never say anything about it, when we came , the medications would be gone." A review of Resident #53's observation notes showed no documentation about medications found anywhere inside the resident's room. On , at 6:19 PM, Staff AP (Medication technician) stated, "[Resident #53] was going to the memory care unit, maybe for few days; she hit her with the floor. She would trash her room; I would say since she was doing it." On , at 10:45 AM, during a phone interview with Resident #53's family member, the family stated, "I would go once every 2 weeks and stay 45 minutes to an hour and a half. I would walk her around. To the day she , she would walk without any aide. She went to the memory care unit in , but they never mentioned that she should be transferred to that unit. She would be there for 3	{A 027}		

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{A 027}	Continued From page 33	{A 027}		

to 4 hours daily. One of the things they were charging us was to assist her in walking to the dining area for her meals. Hospice was only a conversation. At the hospital, she never opened her , but she was moving a lot. The facility's doctor never contacted us to discuss anything; her said that her water retention was due to her , the was working 75%. At the facility, the staff would take the medications to her, and apparently would not wait until she would swallow them, that's why her were ."

Review of Resident #53's record showed a health assessment dated . The resident had a diagnosis of , , , , , , . The resident was alert, and oriented to person, with precautions. The resident was independent on ambulation, and eating, but needed supervision on toileting and transferring, with assistance on bathing, , and grooming. The resident also needed assistance with medications. The record included a hospice evaluation prescription dated .

Review of the facility's 24-hour communication report on between shift 2:00 PM to 10:30 pm, it was requested staff to keep an , on the resident because the resident was not feeling well, ate very little dinner; her vials were normal. There was no documentation in the resident record that the resident received any type of intervention.

A review of facility shift notes for 11/08/2022 between shift 2:00 PM to 10:30 PM, the resident was found in the men's bathroom on the first floor, (from her home on the sixth floor) wearing no pants; she also refused to swallow some of her medications. There was no documentation in

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{A 027}	Continued From page 34 the resident record that the resident received any intervention or medical care. On between shift 2:00 PM to 10:30 PM, the resident was agitated during the evening and have been refusing to take her medications, nurse on duty, and family member were notified. There was no documentation in the resident record that the resident received any intervention or medical care. On shift 6:00 am to 2:30 pm, the resident was unable to urinate and was noted . There was no documentation in the resident record that the resident's medical provider was contacted. A review of facility shift notes On , the resident was found in the hallway with no adult brief or bottom clothing on. Further review and a review of the resident record found no documented intervention. There was no documentation that the resident's medical provider was contacted or that the resident received any evaluation or treatment regarding the occurrence. A review of facility shift notes for showed the resident was agitated towards the care and medication and kept getting out of bed walking around. There was no documented follow up. A review of the Medication Observation Record revealed that Resident #53 refused or did not receive medications for 16 days between and . There was no documentation that the physician was notified.	{A 027}		

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{A 027}	Continued From page 35 The following are medications that the resident refused to take: 81 mg (Used to prevent or) - . 2 times (14, 28), . 3 times (10,24,29) 20 mg (Used to reduce the risk of) - . 22 , 10 mg (Used alone or in combination with other medications to treat high ,) - . 28, . 3 times (10,24,29) Polyethylene 17 mg softener (the resident had a , ,) - . 3 times (24, 27, 29) 3.125 mg (used to treat and high ,) - . 28, . 3 times (10,24,29) , 0. .4 % (Used to lubricate ,) - - . 28, . 5 times (5, 8, 10, 24, 29) , 5 mg (Used to treat) - . 28, times (5, 10) , 250 mg (Used to treat , mental and conditions) - . 28, . 6 times (4, 5, 8, 10, 24, 29) 400 mg (Used to treat ,) - . 28, , 4 times (5, 10, 24, 29) 5 mg (Used to treat an overactive) - . 28, . 5 times (5, 8, 10, 24, 29) Torsemide 20 mg (Used to reduce extra fluid in the body caused by such as , , or - . 28. Lubricant , , - . 6 times (4, 5, 8, 10, 24, 29) 50 mg (used to treat , , , , ,) - . 2 times (4, 22) , 25 mg (used to treat a mental or condition such as , or ,) - . 2 times (4, 22) 50 mg (To treat ,) - . 2	{A 027}		

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{A 027}	Continued From page 36 times (22, 30) On [redacted], at 8:06 PM, the Assistant Director of Resident Care was asked where the documentation was stating that medications were found on the resident's bed, or on the apartment's floor, "I was never aware of any medication that was left without taking it, neither from any of the staff or the family." She further stated that the Medication Technician should have reported these occurrences to her so that the resident could have received medical follow up. In reference to the resident going every day to the memory care unit for supervision, Staff AG stated, "We did not document that." Also, in reference to an [redacted], done at 2:30 PM, the same day of the [redacted], Staff AG stated, "I don't know, Staff should know, I was not working with this resident. I know it is not documented." Class I	{A 027}		
{A 058} SS=E	429.42( ) FS; 58A-5.033(3)(a) FAC Pharmacy & Dietary; Uncorrected Deficiencies 429.42 Pharmacy and dietary services.- (1) Any assisted living facility in which the agency has documented a class I or class II deficiency or uncorrected class III deficiencies regarding medicinal drugs or over-the-counter preparations, including their storage, use, delivery, or administration, or dietary services, or both, during a biennial survey or a monitoring visit or an investigation in response to a complaint, shall, in addition to or as an alternative to any penalties imposed under s. 429.19, be required to employ the consultant services of a licensed pharmacist, a licensed registered nurse, or a registered or	{A 058}		

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{A 058}	Continued From page 37 licensed dietitian, as applicable. The consultant shall, at a minimum, provide onsite quarterly consultation until the inspection team from the agency determines that such consultation services are no longer required. (2) A corrective action plan for deficiencies related to assistance with the self-administration of medication or the administration of medication must be developed and implemented by the facility within 48 hours after notification of such deficiency, or sooner if the deficiency is determined by the agency to be life-threatening. 58A-5.033(3) (3) EMPLOYMENT OF A CONSULTANT. (a) Medication Deficiencies. 1. If a class I, class II, or uncorrected class III deficiency directly relating to facility medication practices as established in Rule 58A-5.0185, F.A.C., is documented by the agency pursuant to an inspection of the facility, the agency must notify the facility in writing that the facility must employ or contract the services of a pharmacist licensed pursuant to Section 465.0125, F.S., or registered nurse as determined by the agency. 2. After developing and implementing a corrective action plan in compliance with Section 429.42(2), F.S., the initial on-site consultant visit must take place within 7 working days of the notice of the class I or II deficiency and within 14 working days of the notice of an uncorrected class III deficiency. The facility must have available for review by the agency a copy of the license of the consultant pharmacist or registered nurse and the consultant's signed and dated review of the corrective action plan no later than 10 working days subsequent to the initial on-site consultant visit. 3. The facility must provide the agency with, at a	{A 058}		

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{A 058}	Continued From page 38 minimum, quarterly on-site corrective action plan updates until the agency determines after written notification by the consultant and facility administrator that deficiencies are corrected and staff has been trained to ensure that proper medication standards are followed and that such consultant services are no longer required. The agency must provide the facility with written notification of such determination. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to correct deficiencies relating to assistance with self-administration of medications on three previous surveys. The facility is required to contract the services of a licensed pharmacist or registered nurse that will provide at least quarterly consultation until the Agency for Health Care Administration determines that these services are no longer needed. Findings included: Review of facility's record revealed during a complaint investigation on , the facility was cited for deficient practices relating to medications with self-administration, medication administration, medication records, medication storage and disposal, and medication labeling. During a revisit survey conducted on , the facility was cited for deficient practices relating to medication administration and medication records. The facility was also cited for deficient practice relating to pharmacy and dietary uncorrected deficiencies of medications. During a second revisit survey conducted on , the deficient practice regarding pharmacy and dietary was found to be uncorrected.	{A 058}		

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{A 058}	Continued From page 39 Observation on . . . . . at 08:38 AM showed deficient practice relating to medication storage and disposal. Discontinued medications were found in the medication cabinet. On at around 02:58 PM, Administrator acknowledged the deficient practices by stating she had no questions regarding it. Uncorrected Class III	{A 058}		
{A 079} SS=L	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.	{A 079}		

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{A 079}	Continued From page 40 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 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 , , , ( ) 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 . 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 , , 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	{A 079}		

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{A 079}	Continued From page 41 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 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	{A 079}		

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{A 079}	Continued From page 42 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 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	{A 079}		

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{A 079}	Continued From page 43 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 observation, record review and interview, the facility failed to provide adequate staffing to meet the scheduled and unscheduled needs for 78 out of 78 residents, including eight (#5, #11, #17, #27, #48, #88, #92 & #104) residents under hospice care. The facility had only three staff on duty during the overnight shift to care for 78 residents. The facility also failed to respond to more than 113 pendant calls for assistance, for periods exceeding 15 minutes, including one call for assistance that went unanswered for more than an hour for Resident #108 who had a . Findings: 1) A review of Resident #108's nurses notes dated . . . . . revealed the following: "Resident slipped in the bathroom." The notes further stated that resident said that he slipped in the bathroom, but he denied , . Doesn't know how he ended up in bed. When asked about pendant stated, "he didn't know." The notes stated further that the resident was transported to the hospital by a family member. There was no documentation that Resident 108's pendant worked. A review of the pendant call log for . . # . . dated showed that the pendant was pressed at 12:50 PM on . . . . . and elapsed for one minute three seconds. The resident was not in the room.	{A 079}		

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{A 079}	Continued From page 44 A review of Resident #108's hospital records dated showed the following: "Resident #108 is a male with High , and presents to the Emergency Department with overnight. Patient reports that he was in the bathroom and or possibly passes out and laid on the floor overnight at least 7 hours. He called the emergency line several times, but it was "broken" as no one came to check on the patient. This morning he was transferred to the bed and continues to remain . Son at bedside brought patient to the emergency department for evaluation. Patient denies local, or , or . Does not take for any reason. Denies . CT (Computed) a diagnostic imaging) demonstrates doctor immediately contacted and requested transfer to another hospital emergency department where he is requesting a CT plane on the machine at the hospital. This will determine if the is evolving and will guide his next steps in management." Interviewed on at 11:26 AM the former Wellness Assistant stated, "[Resident #108] on on a Friday or Saturday morning. Nobody went to his room. The Assistant Director of Residents called me to activate a new pendant for him (#108). I was out Christmas shopping. A new certified nursing assistant (Staff AR) was working overnight. She [Staff AR] did not check the room. His daughter found him on the floor. The resident staid that he asked her for help and she left saying she was coming right and never came . He said that he was on the floor all night. They did not do an incident report."	{A 079}		

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{A 079}	Continued From page 45 Interviewed on at 2:14 PM the son of Resident #108 stated that his father suffered a severe which resulted in a surgery from the he had on . The son stated further, "Right now my focus was my father coming out of surgery. My sister found him on the floor between 7 AM-8 AM on . She took a lot of pictures. They're supposed to do checkups. He spent seven to eight hours on the floor. He pushed the pendant, but it did not work." Interviewed on at 11:11 AM Staff AR (Caregiver) stated, "On , I was conducting my final rounds. [Resident 108] was laying in the middle of the bed sleeping at 5:00 AM. He told me he was laying on the floor all night. I told him that was not possible because he was on his bed. I then checked the bathroom and there was no indication of a . I did not see , water, or any on his skin." Staff AR stated further that staff still document rounds every two hours and that the resident had a camera in the room. Observation on at 4:10 PM found no camera inside Resident #108's # Interviewed on at 11:14 AM the daughter of Resident #108 stated that she found her father on the floor. She stated that she was able to speak to him while he was on the floor. She stated that the incident occurred on . The daughter stated, "My father said that he pushed the pendant." When asked where the pendant was, she (daughter) stated that she thought it was on the floor. The daughter stated, "I know he pushed it (pendant). My father said that someone (staff) said that they were going to get help but never came . When I found him	{A 079}		

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{A 079}	Continued From page 46	{A 079}		

on the floor, I ran to the second floor to find somebody. I found a home health nurse. There was no staff to help me. I did what I thought was the best thing for my father. I was happy she (home health nurse) was there. I needed help. It was between 8 AM-9 AM. I know it was Christmas eve. It was early. The (facility) said they were going to do an internal investigation and people was going to be fired. The home health nurse assessed him. I had to get in touch with my brother. They were going to call for a private ambulance to take him to a hospital, but my brother took him to another hospital. We don't have a camera in the room."

Interviewed on at 11:22 PM when asked about Staff AR conducting rounds on on the 10th floor # from 12:00 AM through 6:30 AM, the Administrator stated, "I have photos of Staff AR doing her rounds on .. .. up to 5:00 AM." When asked about any photos or videos showing staff going into the Resident #108's Room, the administrator stated she only had captioned pictures of Staff AR coming off the elevators of the floor she was assigned on. The administrator stated further that the cameras were not equipped or had not been set up to show a view of the hallways. The administrator stated, "I don't know why it was like that."

Interviewed on at 2:50 PM, the Home Health Nurse stated regarding Resident #1108' on , that it was the daughter who came and got her from her office on the 2nd floor because the daughter stated that her father (Resident #108) was on the floor. When asked how long the resident said that he was on the floor, the Home Health Nurse stated, 'for a while' . The Home Health Nurse stated further, "He

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{A 079}	Continued From page 47 seemed . . . . . He had a . . . . . on his arm. I don't know how long he was on the floor. He may have hit his arm on the door jamb because there was some paint that came off." The Home Health Nurse stated that he may have between the bathroom and the closet door, adjacent to the wall between the bathroom door. The Home Health Nurse stated that it may have been around 9:00 AM when the daughter came and that there was no on the floor or . . . . . . A review of the hospital records showed that resident #108 was admitted on to the . . . . . (. .) and was discharged on . . A review of nurse's notes for Resident #108 showed that he had a . on . . . . . and on . There was no documentation of a . prevention intervention. A review of the pendant and room call light logs, which documented when Resident #108 pressed the pendants to request staff assistance on for # , showed his call light went unanswered for more than 59 minutes after pressing the pendant at 10:33 PM on /202). A review of the Resident #108 Progress dated . . . . . noted the following: "Received report that on . . 11:20 PM resident was noted on floor by armchair." A review of Resident 108's Health Assessment for Resident completed on showed diagnoses of , ... , Dyslipidemia, ... , diverticulosis, . . . , ... , tremor, ... ( ). Physical or sensory limitations: Cane	{A 079}		

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{A 079}	Continued From page 48 and/or walker for long distance. [illegible] or behavioral status: Alert times three. Activities of Daily Living showed independence with ambulation, bathing, [illegible], eating, grooming, toileting, and transferring. 2) Observation on [illegible] at 10:30PM on the 2nd floor found only three caregivers, Staff X, Staff AR, and Staff AQ, with 78 residents, including eight (8) residents (#5, #11, #17, #27, #48, #88, #92 & #104) under hospice care. Interviewed on [illegible] at 10:30PM Staff AQ (Shift Leader), stated that Staff AK (Caregiver) called out sick and that she was trying to get another staff to come in to work. Staff AQ stated further that she and Staff N (Caregiver/Medication Technician) switched schedules on [illegible]. Interviewed on [illegible] at 11:22 PM the Administrator stated that she should have been informed that Staff AQ and Staff N switched schedules even though it was approved by Assistant Director of Resident Care. The Administrator stated further that they were contacting staff members to see who could come in to fill the schedule. A review of the facility's records relating to residents' needs for assistance with activities of daily living for a census of 78 residents showed the following: 22 residents needed assistance with ambulation, 45 needed assistance with bathing, 39 needed assistance with [illegible], 11 needed assistance with eating, 20 needed assistance with toileting, and 24 needed assistance with transferring. Residents needing supervision showed the following: 24 residents	{A 079}		

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{A 079}	Continued From page 49	{A 079}		

needed supervision with ambulation, 16 residents needed supervision with [redacted], 16 residents needed supervision with eating, 16 residents needed supervision with self-care, 17 residents needed supervision with toileting, and 19 residents needed supervision with transferring.

A review of the pendant and room call light logs, which documented when residents pressed an alert when they needed staff assistance from [redacted] to [redacted], found the call lights for several rooms listed below went unanswered for more than 15 minutes 27 times in a span of four (4) days:

[redacted], Resident #102 - call light duration 21:19
[redacted], Resident #112 - call light duration 19:53
[redacted], Resident #112 - call light duration 19:03
[redacted], Resident #58 - call light duration 18:36
[redacted], Resident #72 - call light duration 20:12
[redacted],Resident #72 - call light duration 17:49
[redacted], Resident #27 - call light duration 15:41
[redacted], Resident #39 - call light duration 42:00
[redacted], Resident #39- call light duration 44:44
[redacted], Resident #86- call light duration 30:02
[redacted], Resident #68 - call light duration 39:33
[redacted], Resident #58 - call light duration 21:37
[redacted], Resident #58- call light

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{A 079}	Continued From page 50 duration 34:31 , Resident #42 - call light duration 44:40 , Resident #58 - call light duration 29:34 , Resident #62 - call light duration 18:51 , Resident #86 - call light duration 24:10 , Resident #72 - call light duration 32:54 , Resident #112 - call light duration 17:45 , Resident #86 - call light duration 17:00 , Resident #52- call light duration 20:26 , Resident #86 - call light duration 43:40 , Resident #62 - call light duration 27:28 , Resident #27 - call light duration 20:19 , Resident #64 - call light duration 17:24 , Resident #86 - call light duration 53:07 , Resident #101 - call light duration 26:12 A review of Resident #72's Health Assessment dated in # showed diagnoses of , , H ( ), ( ), ( ), ( ), ( ), ( ), 's , ( ), and Defibrillator. Physical or Sensory Limitations showed limited movement, and that	{A 079}		

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{A 079}	Continued From page 51 the resident needed one person assists, and one rolling walker. ِ status intact showed mildly repetitive. Special precautions: (-defibrillator). Activities of daily living showed the resident was independent with eating and self-care and needed assistance with ambulation, bathing, ِ, toileting and transferring. A review of Resident # 42's activities of daily living in # showed the resident was independent with ambulation, eating, ِ, toileting and transferring. A review of Resident #62's Health Assessment dated in # showed diagnoses of , , , ِ , memory , , and non- age related . Activities of daily showed the resident was independent with ambulation, eating, self-care, and transferring and needed assistance needed with bathing, ِ and self-care. A review of Resident #64's Health Assessment dated in # showed diagnoses of atherosclerotic , , , and , . Activities of daily showed the resident needed supervision with eating and self-care and assistance with ambulation, bathing, ِ, toileting and transferring. A review of Resident #86's Health Assessment dated in # showed diagnoses of 's , , , , , and . Activities of daily living showed the resident was independent with eating, needed	{A 079}		

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assistance needed with ambulation, bathing, , toileting and transferring, and needed supervision with self-care.

A review of Resident #112's Health assessment dated in # showed diagnoses of (Hairy Cell), ( ), and . Activities of daily living showed independence in ambulation, bathing, , eating, self-care, toileting and transferring.

A review of Resident #101's Health assessment dated in # showed diagnoses of , a history of right angiopathy without , severe protein caloric . Activities of daily living showed the resident needed supervision with eating and assistance with ambulation, bathing, , self-care, toileting, and transferring.

A review of Resident #39's Health assessment dated in # showed diagnoses of , and . Activities of daily living showed the resident was independent with ambulation, bathing, , eating, self-care, toileting and, transferring.

A review of Resident #58's activities of daily living in # showed that the resident was independent with ambulation, self-care, , bathing, toileting, eating and transferring. The resident needed precautions.

A review of Resident #68's Health assessment

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{A 079}	Continued From page 53 dated in # showed a medical history and diagnoses of ( ), ( ), A. fib ( ); physical or sensory limitations - AKI (Acute , injury), RLE (Refractive Lens Exchange) or behavioral status - AAOx3 (Alert and oriented x3). The resident needed precautions. The resident needed assistance with ambulation, bathing, , self-care, toileting, transferring and was independent with eating; the resident also needs assistance with self-administration of medications. A review of Resident #24's Health assessment dated in # showed a diagnoses . Activities of daily living showed independent with ambulation, transferring, and supervision with bathing, , eating, self-care, and toileting. A review of Resident #52's Health assessment dated in # showed a diagnoses of , major . Activities of daily living showed independent with eating and supervision with ambulation, self-care, transferring, and assistance with bathing, , and toileting. 3) A review of the pendant and room call light logs, which documented when residents pressed the pendants to request staff assistance from to found the call lights for several rooms active without response for more than 15 minutes 135 times, including active without response for over two (2) hours.	{A 079}		

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	AL11969444	A. BUILDING: _____ B. WING _____	R 02/03/2023

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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 079}	Continued From page 54 A review of a grievance form dated 11/02/2022 by Resident #72 to the Concierge regarding pushing the pendant several times read as follows: "Between 8:00 PM-8:30PM. No one come to put and husband into bed on . No one showed up between 8:00 PM-8:30PM. So, she pushed pendant 3 to 4 times. No one came. She ended up putting husband (Resident #73) into bed. No one came all night long. She is concerned. They may have needed help, and no one showed up at time they were to come in. Very hard for her to put him in bed by herself." A review of Resident #73's Health assessment dated showed medical history and diagnoses of Normal pressure ; resident was independent with ambulation, bathing, eating, self-care (grooming), toileting, and transferring, and needed assistance with . The resident was able to self-administer medications. A review of Resident #72's Health assessment dated showed medical history and diagnoses of ( ), ( ), ( ); resident was independent with ambulation, bathing, eating, toileting, and transferring, and needed supervision with and self-care (grooming). The resident was able to self-administer medications. Interviewed on at 11:22 PM, the Administrator acknowledged the problem and stated that things were getting better. Uncorrected Class I	{A 079}		

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{A 162}	Continued From page 55	{A 162}		
{A 162} SS=D	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}		

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{A 162}	Continued From page 56 (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 57 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 58 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to have completed and accurate health assessments for three out of 78 sampled residents (Residents # 4, #17, and #79). Findings included: Observation on [redacted] at 8:46 AM showed Staff AW, Medication Technician (Med Tech), explained to Resident #4 what type of medication she was going to take; she then popped each tablet into a small medication cup and gave to the resident. Observed Resident #4 tried to pour the medication into her [redacted] but instead one of the pills dropped onto the floor. Observed Staff AW replaced the dropped medication, and placed it onto a spoon so the resident could take it. Then observed Resident #4 put the tablet into her [redacted] and then dropped the tablet into her cup of water. Observation on [redacted] at 08:57 AM showed Director of Resident Care (DORC) began to administer medication from a spoon to Resident #4's [redacted]. Observed the DORC then asked Staff AW for apple sauce. The DROC mashed the pills, mixed it into the apple sauce, and fed it to Resident #4. Review of Resident #4's health assessment dated [redacted] showed medical history and diagnoses of [redacted], ASHD (Atherosclerotic [redacted]), A. fib ([redacted]), [redacted]; physical or sensory limitations - ambulate with rolling walker; [redacted] or behavioral status - AAOx1 (Alert and	{A 162}		

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{A 162}	Continued From page 59 oriented x1); resident was in precautions; activities of daily living showed resident needed assistance with ambulation, bathing, selfcare, toileting, transferring and needs supervision with eating; Resident #4 also needs assistance with self-administration of medications. On at 9:05 AM, during an interview with the assistant director of resident care regarding Resident #4 not able to take medication by herself, Assistant Director of Resident care stated, "She is not like this all the time. This is the 1st time I seen [Resident #4] like this." Observation on at 9:30 showed Assistant Director of Resident Care (ADORC) administering medication to Resident #17. Observed ADORC crushed Resident #17's medications with a pill crusher, mixed it into apple sauce, and fed it to the resident with a spoon. Also observed the ADORC mixed the crushed medication within water which had a thickener and pour into the resident's . The resident was unable to assist the staff in placing the spoon into her own . Review of Resident #17's health assessment dated showed medical history and diagnosis of 's , , , Altered Mental States (AMS), , , , , (, ,), Nutritional Deficiency, , , , (, ,), , , , , and behavioral status showed resident AAI X 2 (alert and oriented X2) with episodes of forgetfulness and . Nursing treatment showed resident on the memory care unit (secured environment) and under hospice care. Resident was at risk for . Activities of daily living	{A 162}		

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{A 162}	Continued From page 60 showed resident needed assistance with ambulation, bathing, , eating, self-care, toileting and transferring. Resident needed assistance with self-administration was checked. On at 9:19 AM, during an interview with the ADORC regarding who provides medication to Resident #17, the ADORC stated, "In the evenings, weekends, and the holidays, hospice has a nurse who comes and provides the medication." On at 10:46 AM interviewed the DORC about the change in conditions of Resident #4, the DORC stated, "I don't feel like [Resident #4] inability to take her meds is a change, sometimes she just needs help." Review of Resident #79's health assessment dated showed it was incomplete. The health assessment showed medical history and diagnosis of , , II (type II), ( ), ( ), ( ), ( ), 's (defibrillator. Physical or Sensory Limitations limited movement, one person assists, one rowing walker. status intact; mildly repetitive. Nursing/treatment/, requirements section was left blank; Special precautions: (defibrillator); Activities of daily living showed independent with eating and self-care and assistance needed with ambulation, bathing, , toileting and transferring.	{A 162}		

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{A 162}	Continued From page 61 Uncorrected Class III	{A 162}		

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A 055 SS=D	59A-36.008(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents. (b) Both prescription and over-the-counter medications for residents must be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed; 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or 6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in Rule 59A-36.006, F.A.C. (c) Centrally stored medications must be: 1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times;	A 055		

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A 055	Continued From page 1 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and, 4. Kept separately from the medications of other residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider. (e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the	A 055		

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A 055	Continued From page 2 resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to Rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to return the medications to the resident's representative after the medications were discontinued for one out of 119 sampled residents (Resident #11). Findings include: In an interview on at 9:05 AM, the Assistant Director of Resident Care stated, "[Resident #11] is not any medication besides , . The daughter said she didn't want it. She asked the doctor to discharge the medication. Observation on at 9:45 AM showed packs labeled with Resident #11's name in the medication cart on the 3rd floor near the dining area. The medication included was 20 MG filled on , SOD 100 MG filled on , , 325 MG filled on , 1 GM filled on , 300 MG filled on and Doc Sod 100 MG filled on . On at 9:38 AM, (when asked why [Resident #11's] medication was still in the medication cart, the Assistant Director of Resident Care stated, "I, myself took them off. I'm calling the pharmacy to see why the medication was delivered."	A 055		

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A 055	Continued From page 3 Class III	A 055		